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INTRODUCTION: THE CULTURAL CRISIS OF MODERN MEDICINE

Medical care is a good probe of the quality of a society. It reveals how a society deals with such fundamental individual and social experiences as birth and death, pain, disability, suffering, and aging. Viewed through the prism of its medical care system, the United States appears a very unhealthy society indeed. The twelve essays in this book, unlike most radical critiques of health care, are not concerned primarily with the problem of the distribution of health care (who gets what kind of care and how do they pay for it) but rather with the nature of modern medical care itself. They examine medical care as science and as social interaction. They ask what the real value of scientific medical care is—and what the price of that care is, in terms of physical harm, social dependency, and political impotence. In short, these are contributions to what we might call a "cultural critique" of modern medicine.

In this introductory essay I will discuss the historical and political origins and the principal themes of this "cultural critique." I will also examine its relation (which, we shall see, is partly complementary, partly antagonistic) to the political and economic critique of health care which radicals and socialists have more usually made. Finally, I will lay out some of the elements of a synthesis between the various radical approaches to health care to form a vision of what a truly socialist medicine might look like.

I want to thank Barbara Ehrenreich. Her ideas and criticisms contributed greatly to this essay.

THE RADICAL CRITIQUE OF MEDICAL CARE

To start with, let us recall the more traditional radical critique of medical care—what I will call the "political economic critique." (I should stress that in distinguishing this mode of criticism from the "cultural critique," which I shall come to shortly, I am deliberately exaggerating the gulf between the two for purposes of clarity. In actual practice, although pure forms of each critique are easy to identify, most radical critics of the health system draw elements from both.)

The political economic critique concentrates its fire on the inequitable distribution of health services. To the political economic critic, American medicine at its best is unquestionably beneficial. The problem is that not everyone has equal access to it. The poor are worst off, of course; they simply cannot afford good care (or, in some cases, any care at all). But finances are not the only barriers to care. Poor geographic distribution of doctors and hospitals (e.g., the lack of services in rural areas), lack of general practitioners and other primary care physicians in some areas, racism, etc. all act to deny many American access to acceptable medical care. These criticisms of medical care in the United States apply somewhat less strongly to other advanced capitalist countries (where systems of national health insurance—as in France, Germany, Japan—or national health services—as in England and Sweden—ease the financial burden), although even in these other countries, class and geographic differentials persist. But they apply with redoubled force to the poor countries of the world, where modern health services of any kind are virtually confined to the middle and upper classes in urban areas; the urban and rural poor are simply left to their own devices.

The political economic critique as we have described it so far is shared by liberal and radical critics alike. The two groups part company when it comes to explaining why the health system has been unable to provide readily accessible and affordable medical services for all, and what has to be done to correct the situation. Liberals tend to argue that the United States, at least, does not really have a health *system*; it has a "nonsystem," a fragmented,

uncoordinated mélange of private entrepreneur doctors, independent private and public hospitals, virtually unregulated nursing homes, etc., descended from an earlier era when the organization of health care mattered less because health care was not very effective anyway.[1] The problems would be solved, they argue, by creating an organized health care *system*—national health insurance to enable people to pay for care; government regulation of hospital construction and cost structures; government aid to health manpower training; government sponsored mechanisms to oversee the quality of care.

Radical political economic critics, by contrast, see the private ownership and control of medical and paramedical institutions as the root of the problem.[2] The privately practicing doctors, privately controlled hospitals and nursing homes, privately owned drug and insurance and medical supply companies, are "not in business for people's health," the radicals argue. As long as this situation exists, it remains impossible to plan and regulate the health system in the interests of equity and service. The solution, they assert, is a publicly owned and controlled health system, modeled, perhaps, after that of England or Sweden or after the more completely publicly owned and highly organized health system of the USSR and the European communist countries.[3] Some radicals would take the argument one step farther and say that as long as capitalism—with its private ownership and control of the means of production, distribution and finance—persists, so will the system of unequal incomes, unequal education, unequal health risks, and unequal health services. But as the English and Swedish experiences make clear, socialized medicine, even if imperfect, is possible in an otherwise capitalist country and is quite effective in reducing, if not eliminating, inequities.

The political economic critique, of course, acknowledges that there are problems with health care other than distribution. Services are all too often of low technical quality; doctors and hospital workers may discriminate among patients because of their race or class or nationality or sex; services are often bureaucratically organized and unnecessarily fragmented; and so on. But, and I emphasize this point, these are seen as blemishes, as problems with the *organization* of medical care, and not as intrin-

sic to the nature of medicine itself. Modern scientific medicine *per se*, from the political economic perspective, is seen as an unalloyed benefit to humanity; and the triumph of modern medical practice over every form of superstition and quackery is seen as one of the great technical advances that capitalism will pass on to its socialist successors.

In the last fifteen years or so, another mode of criticism of modern medicine, typified by the essays in this anthology, has emerged. Developing out of the often mutually isolated experience and analysis of several disparate groups, it has not generally been seen as a single critique of the health system. But the separate lines of criticism of medical care developed by militant black community groups, by feminists, by radical psychotherapists, and by health policy analysts concerned with the impact of modern medicine are related, and benefit from being considered together. I will call this synthesis of these criticisms the "cultural critique" of modern medicine.

The political economic critique challenges the poor distribution of an otherwise admirable service; the cultural critique disputes the value of the services themselves. It challenges the assertion, common to liberal and radical critics of the political economic school (as well as to the American Medical Association and the American Hospital Association), that Western-style medical care is effective, humane, and desirable. (The implications of this contention for the questions of distribution raised by the political economic critique are evident: why expand access to something that's no good? I shall have considerably more to say about this problem below.)

What I am calling a cultural critique first appeared in the area of mental health. Psychiatry is the weakest link in modern medical care. Its efficacy is quite low. H. J. Eysenck summed up a 1965 review of the literature on the effectiveness of psychotherapy: "The therapeutic effects of psychotherapy are small or nonexistent and do not in any demonstrable way increase the rate of recovery over that of a comparable group which receives no treatment at all."[4] Eysenck's conclusions have been disputed, but clear evidence for a positive effect of psychotherapy is still lacking. Even among other doctors, psychiatry has relatively low

prestige; and its endemic sectarianism has not made it any more convincing as a scientific discipline. More important, psychiatry is concerned not with clinically measurable somatic disfunctions, but with what is *socially defined* as abnormal or unacceptable behavior. (That this is so is aptly illustrated by R. D. Laing's description of a man "gibbering away on his knees, talking to someone who is not there." It is only because we accept the social definition of this activity as *praying* that we do not see him as *mad*.)[5] Psychiatry unabashedly proclaims its right to make moral judgments. It is the branch of medicine which openly specializes in the *social control* of deviant behavior.

To many, the twentieth-century understanding of alcoholism, drug addiction, homosexuality, etc. as "illness," rather than as sin or crime, seems a triumph of humanity (and compared to eighteenth- and nineteenth-century attitudes, no doubt it is). Expanding access to mental health services became a major goal of medical and other social reformers. But in the 1960s, just as this goal seemed to become realizable (through the Federal Community Mental Health Act, Medicaid, etc.), more and more people—not least, many mental patients and ex-patients—began to question its desirability. The boundaries of the socially and sexually permissible were rapidly expanding. Psychiatry lagged far behind, continuing to define as "sick" (and therefore subject to psychiatric "treatment") what a growing portion of society viewed as normal. More and more young people experimented with self-induced states that were psychologically "abnormal" (produced by drugs, meditation, etc.). Psychiatrists insisted on diagnosing a wide range of behavior—from antiwar activity to black "rioting" to being a "hippy"—as psychotic. The very medical notion of psychosis became suspect, tinged with political and social judgments. Psychiatry stood exposed, not as a science and not as unequivocally benign, but simply as a mode of social control operating to preserve the social status quo. As Thomas Szasz commented in his influential book *The Myth of Mental Illness*:

> Therapeutic interventions have two faces; one is to heal the sick, the other is to control the wicked . . . Contemporary medical practices—

> in all countries regardless of their political makeup—often consist of complicated combinations of treatment and social control . . . . Psychiatric diagnoses are stigmatizing labels, phrased to resemble medical diagnoses and applied to persons whose behavior annoys or offends others.[6*]

During the same period, the Black Liberation movement and other radical community movements began to develop a not dissimilar critique of somatic medicine. For one thing, black, Hispanic, and Asian communities in big cities in the United States repeatedly attacked the racism of the medical system. Both the health status of minority communities and the health care available to them were demonstrably worse than in white communities.[7] More important to the development of a cultural critique of medicine, the actual medical encounters of nonwhite patients with doctors and other health workers were frequently stained by, if not saturated with, racism. Numerous exposés documented widespread medical abuse of nonwhite patients (e.g., involuntary sterilizations, testing of drugs without the patient's knowledge, "dumping" patients from one hospital to another). Even more commonly, doctors and nurses displayed hostile or openly racist attitudes to nonwhite patients. Doctors, hospital administrators, and medical sociologists could not understand why blacks and members of other minority groups did not fully utilize preventive services; failed to communicate clearly with the doctors; did not follow doctors' orders (for use of medications, return visits). The obvious explanation—that the nonwhite patients saw in their contact with the generally white doctors not a technically neutral, personally benign encounter, but a hostile social interaction dominated by the doctor—was evident to the

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* I do not mean to suggest that psychiatry has no therapeutic value under any circumstances, or that all mental disturbance is benign (either from the standpoint of the disturbed person or of society). The whole topic is clouded by the difficulties in defining what constitutes "neurotic" or "psychotic" behavior on the one hand and what constitutes a "cure" on the other. A full discussion is beyond the scope of this essay and this book, which are primarily concerned with a social analysis of *somatic* medicine. The significance of the attacks on psychiatry, for our purposes, is the insights that they provided into the entire medical endeavor.

nonwhite communities if not to the doctors. Like the schools and the welfare system, the medical system began to be perceived not as benevolent but as a system of social control. (The experience of nonwhite patients in the United States with white-dominated health services closely parallels the experience of Algerian patients with French colonial doctors and hospitals, graphically described by Frantz Fanon; see his article, "Medicine and Colonialism," in this volume.) Thus, intensified community struggles against racism forced attention onto the nonmedical aspects of the interpersonal relations involved in medical care.

The radical community movements also developed a growing skepticism about *professionalism*. Doctors and professional (registered) nurses had long insisted that professionalism was a mechanism for maintaining high standards of care and a commitment to social service. But by the mid-sixties, doctors and professional nurses had come to make up only a minority of the people actually delivering health care. The rapid expansion and growing technical complexity of medical services required an explosive growth in the number of nonprofessional health workers—nurses aides, orderlies, ward clerks, therapy aides, community health and mental health aides, and so on. Many of these workers were drawn from the black and other nonwhite communities. They rapidly came into conflict with the doctors and professional nurses. For one thing, they were strategically placed to observe the actual behavior of doctors and nurses and to compare it to the latter groups' self-proclaimed mission of service and compassion. Moreover, in their role as workers, they discovered professionalism was often a defense of occupational and class privilege rather than of high standards. For example, in and out of the hospital, nonprofessional health workers found that it was all but impossible to gain access to professional jobs, which offered higher pay, higher status, and greater opportunities to use their abilities and insights fully. Access to these jobs required passing through an educational gauntlet, set up by the organizations of the (largely white) professionals (the American Medical Association, American Nurses Association, etc.). And the skills and standards imposed by this educational process often seemed arbitrary, determined more by the professionals' desire to limit access

to their occupation (and to insure that only those meeting certain social and cultural standards be so much as eligible) than by any real concern with competency or desire to provide service.[8]

Not only workers, but also community groups became skeptical about professionalism. Seeking a greater say in how community medical institutions (e.g., hospital emergency rooms and clinics) ran, they found doctors using professionalism to defend their administrative powers. "Next they'll try to tell us how to operate," was the common response to community demands such as more convenient clinic hours and bilingual personnel in Hispanic communities. The doctors and nurses might proclaim professionalism to be a defense of high standards. But to nonprofessional workers and community groups it looked a lot more like a defense of power and privilege against the needs of other health workers and the community.

The growing realization that the "emperor has no clothes" did not long remain abstract. In 1968 in a state hospital in Topeka, and a year later in New York's Lincoln Hospital, nonprofessional hospital workers and their allies in the neighboring communities seized control of parts of hospitals and, with the aid of a few young radical doctors and other health professionals, operated certain services themselves. In 1970 in New York, the Young Lords, a radical Puerto Rican organization, "liberated" and operated a mobile x-ray unit and organized medical students and nonprofessionals to screen residents of the Barrio for lead poisoning, anemia, etc. In Chicago, San Francisco, and other cities, radical medical students, nonprofessionals, and a handful of sympathetic doctors operated free clinics in which traditional professional decorum and the traditional division of labor were all but ignored. (For example, in one clinic in Minneapolis, patients were taught to perform their own clinical lab tests; and patients were encouraged to ask questions and talk with doctors as social equals.) The message was clear: possession of professional *skills* did not have to imply a *socially* unequal relationship between doctor, patient, and nonprofessional health worker.[9]

Close on the heels of the radical community movements emerged the Women's Liberation movement. Just as the black movement exposed the racism at the heart of the healing rela-

tion, so the feminist movement revealed its endemic sexism.[10] The unusual aspect of the Women's Liberation movement, from our perspective, is that through it the walls of individual privacy which normally characterize doctor-patient relationships were breached. Women talked to each other and wrote about what actually goes on between a doctor and his patient, a subject heretofore discussed only in the doctors' own biased reports and sociologists' indirect analyses. What was revealed were the countless ways in which doctors acted, in the guise of a medical relationship, to reinforce male domination: female patients (who, I might note, account for some 58 percent of all visits to doctors in the United States made by adults on their own behalf, plus many more visits as the supervisors of their children's health care) were put down, made to feel bad about their bodies, fed masses of misinformation about "proper" female anatomy, sexuality, personality, child-rearing practices, denied control of their own reproductive functions (through access to contraception and abortion), and more. (See the articles by Barbara Ehrenreich and Deirdre English, Diana Scully and Pauline Bart, Mary Howell, and Linda Gordon in this volume.)

The Women's Liberation movement also began to open up the previously taboo subject of the actual technical competency of doctors and of modern medicine altogether. Doctors' practice, it soon became evident, was governed as often by myth as by science. Doctors exhibited massive ignorance on such subjects as menstruation, birth control, menopause, breast-feeding, the proper management of childbirth, vaginal infections, the dangers of hormones (e.g., birth control pills, synthetic estrogens for postmenopausal women), and the dangers of x-rays (e.g., mammography). Sometimes the doctors' ignorance was fairly harmless; other times—for example, with respect to "the pill" and to the management of childbirth (see Doris Haire's article, this volume)—it was less benign; but in any case, it made the doctors' facade of expertise all the more oppressive.

As in the case of nonwhite communities, understanding led to (or sometimes came from) action. Women—individually and in groups—sought to regain control of medical technology for themselves, so that it could be developed and used in their own

interests rather than in the interests of doctors' or of the broader male-dominated society. For some, this meant pushing for a greater number of women in medical school. For others, it meant learning as much as they could about their bodies so as to be better able to challenge the doctors or do without them. (Thus the phenomenal popularity of the Boston Women's Health Collective's *Our Bodies, Our Selves*.) Still others developed new modes of delivery of services (e.g., gynecological self-help, in which women learned to examine and treat themselves or each other for pregnancy, vaginal infections, etc.) and new technologies (e.g., menstrual extraction, in which the menstrual fluid is removed by aspiration in a few minutes rather than through the usual physiological process of menstruation). And some (reinforced, perhaps, by the general antitechnological sentiment common to many feminists and to the sixties counterculture) reopened the exploration of premodern modes of healing—herbal remedies, massage, diet, etc. Counter to prevailing medical opinion, which saw these modes of healing as quackery and superstition, experience suggested that at least some of these methods worked as well as or better than "modern, scientific" medicine.

The final source of the cultural critique of modern medicine was from health analysts from a wide range of political perspectives, who observed that despite the fact that the United States spent more *per capita* on health care (both absolutely and relative to income) than any other nation, the indicators of health status suggested that we had far from the most healthy people in the world. Worse, annual health care expenditures were rising by tens of billions of dollars every year, yet it was hard to see any result in the form of improved health. The earlier part of the twentieth century had seen both dramatic improvements in medical knowledge and technology (e.g., immunizations, antibiotics, open-heart surgery, insulin therapy) *and* significant gains in longevity, infant survival rates, and other indicators of health. The conclusion that the improvements in medicine were responsible for the improvements in health was all but inescapable. But though the medical miracles continued to appear with regularity, and though expenditures on health doubled and redoubled, from

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the mid-fifties on, gains in health were not so easy to come by: the indicators of health status showed little if any change (see accompanying table).*

Indicators of Health Status

	1920	*1940*	*1955*	*1970*
Infant mortality rate[a]	85.8	47.0	26.4	20.0
Male life expectancy at birth[b]	53.6	60.8	66.7	67.1
Female life expectancy at birth[b]	54.6	65.2	72.8	74.8
Male life expectancy, age 40[b]	29.9	30.0	31.7	31.9
Female life expectancy, age 40[b]	30.9	33.3	36.7	38.3
Personal health care expenditures (billion dollars/year)	n.a.	3.5	15.2	60.1

[a] Deaths, per 1000 live births, in first year of life

[b] Years

Sources: U.S. Bureau of Census, *Statistical Abstract of the United States, 1975* (Washington, 1975); United States Bureau of Census, *Historical Statistics of the United States, Colonial Times to 1957* (Washington, 1960); Herbert Somers, "Health Care Costs," in Boisfeuillet Jones, ed., *The Health of Americans* (New York, 1970).

Indeed, chronic and degenerative diseases such as heart disease and cancer, which affect primarily older people, had reached epidemic proportion. One result: in the two decades between 1950 and 1970—while health-care expenditures in-

* Indicators such as life expectancy are, of course, very crude indicators of how healthy a people are. If, for example, people's lives were freer of pain, though their longevity was no greater than in earlier centuries, we would properly conclude that their health had improved though their life expectancy had not. There does not, however, seem to be any compelling evidence that this is in fact what was happening in the fifties and sixties. (See Powles, "On the Limitations of Modern Medicine," p. 3).[11]

creased by $50 billion and the Medicare program dramatically expanded health-care opportunities for the elderly—male life expectancy at age sixty-five increased by just four months (from 12.8 years to 13.1 years)!

A growing disillusionment with the effectiveness of medical care led analysts to reexamine the presumed connection between earlier improvements in health and medical care. As early as 1959, microbiologist René Dubos had pointed out that most of the decline in the death rate from tuberculosis (the major killer of the nineteenth century in Western Europe and the United States) had *preceded* the availability of medical technology which could have had any impact on the disease. Dubos argued that factors other than medical care—e.g., better nutrition—must account for the improvement in health which the decline in tuberculosis implied. Thomas McKeown has dramatically extended Dubos' insight: McKeown examined the cause of the decline in deaths from a group of diseases whose disappearance as major killers accounts for the bulk of the decline in the overall death rate in England since the early nineteenth century (tuberculosis, scarlet fever, typhoid, typhus, cholera, diarrhea and dysentery, and smallpox). He concluded that the reasons for their disappearance as major causes of death were, in order of importance: first, improvements in the standard of living (e.g., nutrition, housing); second, improvements in control of the environment (e.g., water supply and other sanitary services); and only *third*, personal medical care. John Powles and A. L. Cochrane have summarized further evidence that the death rates for a number of major noninfectious diseases (e.g., cancer, heart disease) have not responded to modern medical approaches. Echoing the contentions of some feminists who charged that scientific medicine had been overrated, these studies suggested that modern medical care was and is, at best, much less effective at reducing morbidity and mortality than the doctors have claimed and most people have believed.[11]

Dubos, Hans Selye, and a number of other analysts suggested that part of the limitation of modern medicine lay in the approach to the causes and treatment of disease characteristic of Western medicine since the late nineteenth century (see Marc

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Renaud, this volume). Modern Western medicine has been largely based on: (a) the doctrine of specific etiology: each disease is caused by a specific cause; if the cause (e.g., a germ) is present, the person will get the disease, if it is not, he or she will not; and (b) the machine model of the body: the body is conceived of as a machine, made up of a group of interacting physical (and chemical) parts; the functioning of these parts is independent of the mind of the organism. These doctrines have provided the underpinnings for much of the advance of scientific medicine. However, their limitations, even in dealing with infectious disease, have become more and more evident. Dubos, Selye, and others have stressed a multiple-cause model of disease, in which body, mind, and environment (including, but not limited to, exogenous microorganisms) *interact* to produce disease or to cure it; they have called for the reexploration of more holistic approaches to health and disease.[12]

These suggestions found sympathetic ears in the movements of the sixties. The black movement was stressing the socioeconomic roots of the poor health of their community—poor housing, poor nutrition, high levels of pollution, tremendous stress, and so on. The environmental movement was uncovering and publicizing the role of air and water pollution in causing disease; the occupational health movement (e.g., the Black Lung movement among coal miners) was doing the same for health and safety hazards on the job. And the counterculture was rediscovering the supposed health benefits of vegetarian diets, stress-reducing techniques, etc., while exploring ancient—often Oriental—health doctrines which take a more holistic view of disease processes.*

* The illogic of the conventional modern medical approach to contemporary problems of disease nowhere appeared so clear as with respect to cancer. Hundreds of millions of dollars a year are spent on the search for the biological mechanisms of carcinogenesis and tumor growth and for curative techniques. The patient diagnosed with cancer faces, at best, devastating courses of radiation or drug therapy or debilitating radical surgery. And yet, it is widely known that some 80 percent to 90 percent of all cancers are caused by largely avoidable environmental hazards—air pollution, smoking, food additives, pesticides, radiation, etc. Scientific medicine, for all its insights into the molecular mechanisms of carcinogenesis, has simply become unhinged from any fundamentally effective approach to the disease.

Critics of medicine such as Dubos were simply arguing that medicine was less powerful than it had claimed to be. But a further stream of criticism argued that modern medicine was both physically and socially *harmful*. The dangers of supposedly safe medications had been publicized in the early 1960s in cases such as the Thalidomide tragedy. But it was the feminists' exposure of the dangers of oral contraceptives in the late sixties that made this a continuing concern to a mass audience.[13] Soon information was accumulating on the prevalence of unnecessary (and often risky) surgery, on doctors' over-readiness to prescribe inappropriate or dangerous drugs, on overuse of dangerous diagnostic procedures, and more. Ivan Illich dramatically summed up the wide extent and devastating impact of such "iatrogenic disease" (disease produced by diagnostic or therapeutic procedures):

> The medical establishment has become a major threat to health . . . The pain, dysfunction, disability, and anguish resulting from technical medical intervention now rival the morbidity due to traffic and industrial accidents and even war-related activity, and make the impact of medicine one of the most rapidly spreading epidemics of our time.[14]

The actual harm done by medicine is not limited to physical disability, argues Illich, nor are harmful diagnostic and treatment procedures the only sources of medical injury. The entire social organization of medical care conspires to produce ill health: medical bureaucracies "create ill health by increasing stress"; suffering of all kinds becomes "hospitalized" while our homes become "inhospitable to birth, sickness, and death"; and people become increasingly dependent on the support of the organized medical system to the point where they are unable to deal themselves with their own bodily and spiritual needs. Indeed, he continues, "suffering, mourning and healing outside the patient role are labeled a form of deviance."[15] To Illich, then, medicine has become a major form of *social control*, drawing to its bosom a greater and greater part of the critical events of life and managing our responses to them. Regardless of whether it manages them well or badly, in the end it reduces our own ability to handle our own lives: it produces dependent, helpless people. The conclu-

sion that an increasing array of individual and social problems had become "medicalized" (i.e., had come to be seen as problems which the medical system could and should handle) was also reached by Irving Zola (see his article, this volume) and by Barbara Ehrenreich and myself (see her article, this volume). Zola suggested that the impact of the medicalization of social issues was to "depoliticize" them—to make problems stemming from social causes appear instead to be individual deviancy, solvable (or at least controllable) by the individual's doctor. Barbara Ehrenreich's and my own concern grew directly out of the questions about the doctor-patient relationship raised by the black and feminist movements. What is the impact, we asked, of a system which throws women, blacks, working-class people into intimate and complete dependency on white, male, upper-middle and upper-class doctors? The relationship, we suggested, is a powerful mechanism producing acquiescence in the overall social structure and its values.

We can now sum up the principal contentions of the cultural critique of modern medicine: modern medical care, contrary to the assumptions of the more traditionally radical political economy critique, does not consist of the administration by doctors of a group of morally neutral, essentially benign and effective techniques for curing disease and reducing pain and suffering. The techniques themselves are frequently useless and all too often actually physically harmful. The "scientific" knowledge of the doctors is sometimes not knowledge at all, but rather social messages (e.g., about the proper behavior of women) wrapped up in technical language. And above all, both the doctor-patient relationship and the entire structure of medical services are not mere technical relationships, but social relationships which express and reinforce (often in subtle ways) the social relations of the larger society: e.g., class, racial, sexual, and age hierarchy; individual isolation and passivity; and dependency on the social order itself in the resolution of both individual and social problems. (These characteristics of medicine are exhibited in almost caricature form in the imperialist uses of medicine—see the essays by James Paul, E. Richard Brown, Howard Levy, and Frantz Fanon in Part 3 of this book. As Marx commented, in writing of

the relevance of the relatively clearly developed social relations of 1860s England for more backward regions where capitalist relations were not so obvious, "Of you the story is told.") The assumption made in the political economic critique—that modern medicine, distributed through an equitable delivery system, would be enthusiastically embraced by a socialist society—is thus thrown into question. At its very core, asserts the cultural critique, medicine as we now know it is a capitalist mode of healing. What *parts* of it can be taken over into socialism is quite uncertain.

THE LIMITATIONS OF THE RADICAL CRITIQUE

I have described the major directions taken by radical criticism of the health system in recent years. Both the political economy critics and what I have called the "cultural" critics make compelling criticisms of contemporary medical care. But a word on their limitations is in order.

The political economic critique follows the conventional Marxist pattern of analysis: medical care is treated as a commodity like any other; the important things about medical care can then be derived from the general laws for the production and distribution of commodities. (Of course, in the case of medical care and other services, production and distribution occur simultaneously.) The primary problems that the political economic critic identifies by this analytic approach, then, are distributional: poor and working-class people in the United States and elsewhere do not have access to adequate care. By contrast, in a socialist society, health care would be socialized and everyone would have equal access to high quality care.

But medical care as we know it—i.e., as it has developed in capitalist society—is not just an unambiguously useful commodity like asparagus or shoes or swimming lessons. Like many other more complex commodities, it is thoroughly permeated with capitalist priorities and capitalist social relations. Not merely the distribution, not merely the transaction between doctor and patient, but the medical technology itself (which is based on certain assumptions about the nature of disease processes, the causation

and cure of disease, the relations of individuals to their own bodies and to social processes) embodies the social relations created by capitalistic society. It is by no means clear that we want to pass *these* along to socialist society; i.e., *socialized* medicine is not necessarily *socialist* medicine.

Medicine is not unique in this respect, of course. There are many other cases in which apparently neutral and objective technology is in fact penetrated by and helps recreate the social relations of the society which developed it: the single family housing unit presupposes (and creates) a noncollective mode of living; individual automobiles imply an entire conception of use of energy, use of time, and spatial organization of society; assembly line production techniques and machinery assume and reinforce the separation and antagonistic relation between mental and manual labor; and so forth. In medicine it is not quite so evident that this is the case. For one thing, an unusual amount of mystery surrounds the technology (the result, in part, of doctors' efforts to keep their knowledge esoteric); for another, the presumably benevolent purposes of the medical endeavor provide an unusually opaque disguise for the sometimes antagonistic social relations built into it.

The political economic critique, however, also seems to me to overemphasize the commodity-like nature of medical care altogether. The healing relation is not simply a commercial transaction. It is also a *direct* social relation between two people (usually of sharply differing class or sex or race), unmediated by the commodity form. The doctor is actually in there, touching and penetrating your body, asking intimate personal questions, giving you orders to follow at your life's peril, sympathizing and caring or scorning and disparaging. To more than one political economic critic—for whom only those matters stemming directly from relations of production are real, material, and worthy of respect—the personal interactions which go on in the doctor's office are unmaterialist, of no interest. This seems to me an extraordinary example of what Marx called the "fetishism of commodities," in which relations between people appear in the guise of relations between the products of their labor. To be sure, one aspect of the relation between doctor and patient is a com-

modity relationship—the doctor as producer and seller of the commodity of medical care, the patient as purchaser and consumer. But simultaneously, it is a direct relationship of personal support, of domination—even, in some cases, of physical exploitation. It is hard to see how much more "material" you can get than this. Marx's and Engels' comment in *The German Ideology* reminds us that a materialist analysis involves more than "economic" activities:

> We must begin by stating the first premise of all human existence, and therefore of all history, the premise namely that men must be in a position to live in order to be able to "make history." But life involves before everything else eating and drinking, a habitation, clothing, and many other things [including, presumably, care of the sick or disabled—ed.] . . . The production of life . . . appears as a double relationship: on the one hand as a natural, on the other hand as a social relationship.[16]

That social relations are contained in medical technology and in the healing relationship is far from a matter of purely academic interest. Understanding those social relations is the key to understanding how medicine, as it has gained in technical mastery over bodily processes, has lost its ties to people's daily mode of life, to their individual and social feelings about birth, death, suffering, pain and dependency. And this, in turn, helps us to understand such contemporary phenomena as the decline in faith in medicine; the continued influence of premodern healing modalities; the investing of supposedly technical medical questions—such as the effectiveness of Laetrile—with major political content; and the spread of "neurotic" dependency on the medical system with consequently soaring utilization and soaring expenditures.

The cultural critique thus has major political implications for health policy. The question raised by conservatives—why should we go on pouring money into health care when the only result is a rise in utilization of medical services without corresponding improvements in health?—is a reasonable question. Within the narrow political economic framework, however radical, it is unanswerable. Conversely, the lack of mass popular support for the various proposals for national health insurance or for bureau-

cratic forms of socialized medicine reflects the unarticulated understanding that there is something very wrong with medicine as we have come to practice it.

The political economic critique, of course, emerges out of a consciousness of scarcity and so it is less concerned about the nature of medical services than about their existence at all. The cultural critique, by contrast, emerges out of consciousness of plenty. It should not be thought, however, that it is thereby irrelevant to the poor nations of the world or to the needs of poor people in the rich countries. It may be true that it is only when we have the luxury of plenty that we can, for the first time, examine closely just what it is that we have plenty of. But the insights that the cultural critique has reached about medical care, if not the conditions under which it reached them, are highly significant for medical care in any society.

To give an analogy: it is primarily in the more affluent, industrialized countries that the knowledge, resources, and industrial need for new technological developments generate the rapid advance of science and technology. It goes virtually without saying that we expect the poor countries of the world to want and to use the scientific and technical insights developed under the conditions of the wealthy countries (including, often, the insight that technologies installed in the rich countries only a very few years ago may already be obsolete or otherwise faulty and should not be imitated, if possible). Ironically, the matter somehow seems more problematic when it comes to insights directly affecting human health and safety, such as the recent concern in the affluent countries over the dangers of industrial pollution, of nuclear power plants, of unsafe occupational conditions. In these cases, concern for overall development understandably comes first; but the very low priority often given to the insights on the potential *adverse* impacts of industrialization, the lack of significance ascribed to the dialectical relationship between the achievements and the tragic failures of the rich countries, is disturbing. The lesson that advanced capitalism teaches so clearly—that human well-being can not be guaranteed by industrialization—is certainly not the least important lesson to be learned from the affluent countries.

Returning to the case of medical care, the cultural critique's

concern for the overall efficacy, safety, and social impact of Western-style scientific medicine has wide application—to the poor as well as to the more affluent, to the industrialized socialist countries as well as to the industrialized capitalist countries, to the developing nations and to the developed. In fact, the cultural critique developed in the affluent West drew in part on the parallel approaches to medical care taken by the decidedly nonaffluent Chinese. Especially during and since the Cultural Revolution of 1966-1969, the Chinese health-care system has embraced many of the policies advocated by cultural critics of the United States and England—policies such as the radical deprofessionalization of medical care (e.g., barefoot doctors, shortened academic training of doctors); promotion of egalitarian relations between doctors and patients and other health workers; integration of holistic, traditional modes of medicine with Western modes; involvement of patients as active participants in their own cures; and concern with the social and political roots of disease.[17]* Many aspects of these policies stem from broader social and political concerns rather than from analysis of the problems of medical care *per se*, of course. But, as I shall discuss below, as soon as the assumption that medical care is merely a commodity is rejected, the fusion of questions of health policy and of overall political and social values is exposed.

The various critiques of scientific medicine which I have grouped together as the "cultural critique" are not *uniformly* applicable to nonaffluent situations, however. Far from it: parts of the cultural critique, in their extreme formulations at least, show clearly their origins in what the Chinese would call a "fat" country, and exhibit a serious lack of concern about the situation of scarcity which characterizes medical care for most of the world (and for a not inconsiderable part of the United States as well).

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* Whether any of these policies stem from a Chinese analysis of Western medical experience (other than in its imperialistic form in pre-Liberation China) is questionable. Western concerns with the social impact of air pollution and of occupational health hazards do not appear to have found much echo in China. (Environmental concerns exist, but seem more aroused by problems of waste and efficiency than by potential health problems.)

Taking an obvious example, when Ivan Illich insists that "A world of optimal and widespread health is obviously a world of minimal and only occasional medical intervention,"[18] from the perspective of those who now have "minimal and only occasional medical intervention" he has "obviously" overstated the case against modern medicine to the point of vitiating the entire cultural critique.

Modern medicine does work, does prevent death and reduce pain and suffering, even if less often and less effectively than its admirers have claimed. For example, in a 1968 National Academy of Sciences study of the impact of prenatal and postnatal care on infant birth weight and infant mortality, women were classified according to their ethnic group; according to medical and social criteria indicating whether their babies were at high risk (e.g., a tubercular mother or a mother living in a slum area would be placed in the high risk category); and according to the adequacy of the medical care they received. In every risk group and every ethnic group, the more adequate the medical care, the more likely a favorable outcome (i.e., a healthy baby). Among low-risk mothers, improvements in medical care above a certain fairly low level had relatively little effect; but among higher risk mothers, every increment in medical care markedly improved the baby's chances of survival. Other studies have come to similar conclusions: statistically, at least, above a relatively modest level of medical care services, the marginal impact of additional medical services is low. But below that level of services, the reverse is true: providing medical services, even in the absence of changes in environment, housing, nutrition, and so on, produces significant improvements in health.[19] And, of course, numerous clinical trials and much clinical experience provide evidence for the beneficial impact of medical care in the case of particular diseases in individuals.

How, then, can we explain the overall failure of health to respond to additional inputs of medical care, as charged by Illich, Powles, and other cultural critics? We may, of course, simply be using inappropriate measures of health status.[20] More likely , the losses to health resulting from the combination of incompetent medical practice, poor distribution and low accessibility of ser-

vices, poor patient compliance with doctors' instructions, growing environmental hazards, and clinical iatrogenesis (exaggerated by inappropriate and excessive uses of technology) balance off the gains in health produced by medical intervention. But not all of the negative influences on health are intrinsically associated with the United States' mode of medical practice. The cultural critique has properly identified causes of health and disease, both outside the purview and concerns and powers of modern medicine and within medical practice itself. But, seen from the perspective of those who now do not have access to modern medicine (the majority of the world's people), it has not made a case for eliminating most of medicine altogether.

Cultural critics, as we have seen, have also denounced medicine as a mode of extending bourgeois cultural and political hegemony. Medicine, they argue, produces dependency and reduces individual autonomy; it reinforces racism and sexism; it depoliticizes a variety of social (class, race, gender) issues in such a way as to make them seem like individual problems. In sum, it is a major instrument of bourgeois domination. All of these concerns seem to me to be relevant not only to our own situation but also to people presently lacking care as they seek access to medical services or seek to construct new health systems. But as was the case with the critique of the curing capacity of medical care *per se*, legitimate concern all too quickly can become one-sided. Medicine does have these impacts, among others, but in describing how medicine shapes culture, it is easy to fall prey to a kind of elitest snobbery: culture appears as something which is simply "laid on" a passive, helpless mass. But the complex dialectical interplay between fundamental needs and manipulated needs, between the need for dependency and the need for autonomy on the part of patients, between benevolence and domination and greed on the part of doctors and health institutions, needs dissection, not mere denunciation. The dependency and passivity characteristic of modern medical care are sought by patients as well as imposed by doctors; they reflect not only the interests of the doctors and of giant corporations, but also the needs of patients. Medicine as practiced in the United States may rein-

force dependency and passivity in the face of bourgeois domination; it does not, however, *create* them.

TOWARD A SOCIALIST HEALTH POLICY

The two modes of radical criticism of medical care—the political economic critique and the cultural critique—appear to be at least partly incompatible: the political economic critique is based on the assumption that modern medical care is worth having and struggling for, the very assumption that the cultural critique denies. The incompatibility between the two seems especially evident when medical services are cut back. With assaults on social services of all kinds the order of the day in the industrialized countries, restoration of the services available a few years ago seems highly desirable. But the cultural critique, with its stress on the limits of modern medicine, seems to play right into the hands of conservatives. To policy makers looking for justifications for continuing cutbacks in health services or trying to resist popular pressures for comprehensive (and expensive) national health insurance programs, the cultural critique provides a certain "liberal" legitimacy. (It is, of course, the part of the cultural critique which insists upon the uselessness of medical care that they seize upon; fiscal conservatives have not, to my knowledge, argued that health services should not be extended because they are inherently racist and sexist, or because they help preserve and legitimate the status quo!)

Conversely, hard times have led many liberals and radicals to reject the cultural critique entirely. It seems to them self-evident that the perception of scarcity, not the dangers of plenty, is the sense of grievance out of which a movement to demand the restoration and expansion of social services can come. Some even go so far as to drop the more radical versions of the political economic critique as politically impractical; they replace, for instance, the demand for a national health service with the demand for a national health insurance system (i.e., a system to finance care, which would remain privately delivered and controlled).[21] Others preserve parts of the cultural critique, but only

nominally: they relegate changes in the nature of health care and the meaning of health to some far-off postrevolutionary period, when the class control of health institutions will have changed; for all present and practical purposes, they limit their demands to those flowing out of the political economic critique.[22]

But to limit the critique of medicine to complaints about its scarcity is to surrender the insights gained in the last few years; it is to say that despite the powerful critique of medical care developed in the last decade, we will take any crumbs that they will give us. This, of course, is precisely one of the "purposes" of cutbacks and recession in capitalist society: to make people satisfied with, even grateful for, much less than they had come to expect and demand.

The dilemma is a familiar one in Left history, of course. On the one hand, a "cultural critique" of existing institutions seems irrelevant in the face of existing scarcity. The tendency is to put it off until some affluent, postrevolutionary and "post-scarcity" period. On the other hand, struggling around the distribution of commodites, when the demand for these commodities and the commodities themselves have been hideously deformed by bourgeois social relations, risks falling into the narrowest, most limited reformism. "Reform or revolution"—upon the pole of this dichotomy the Left has been stuck for more than half a century.

How can we escape this dilemma? How do we build a movement that can go from what we have to what is implied by the full radical critique of medical care, given that even what we have now is endangered? Much of the argument between proponents of the two modes of critique seems to me sterile, unable to provide insight into this question. To develop a socialist health policy we must create a dialectical understanding of the crisis in medical care which draws from and integrates both political economic and cultural concerns.

To start with, we must reject the belief that the two approaches to criticizing medical care are actually contradictory. It is only the stagnation of mass movements in the present period that makes them seem incompatible: if there were a large-scale popular demand for improved health care, the two critiques would not appear to be in conflict. And conversely, it is only by connecting

the two critiques that such a popular movement is possible. Let us examine these assertions.

First, neither the demands growing out of the political economic critique nor the demands growing out of the cultural critique can be realized save through a mass movement. In the case of the political economic demands, this is perhaps self-evident: the vested power of the doctors, drug companies, insurance companies, etc. can only be overcome through a massive popular upsurge. On the face of the matter, some of the demands growing out of the cultural critique—e.g., for a health system based on more self-help, for less dependency on professional medical care, for an approach to health emphasizing the importance of personal habits such as eating, exercise, smoking, etc.—do not appear to require such confrontations with economic and political power. But they do require major changes in how people perceive themselves, their bodies, their relationships to others; they do require the unleashing of people's imaginations. And it is only under conditions of massive involvement in a social movement that these changes are likely to occur.

Moreover, a mass popular movement could readily embrace the demands growing out of both critiques. The sixties provide a relevant model: as we have seen, the cultural critique grew in large measure out of the radical community and feminist movements of this period. This suggests that the notion advanced above, that the political economic demand for "more" grows out of scarcity and that the cultural demand for "different" grows out of plenty is, perhaps, too simple and static. Mounting scarcity can beget passivity, as we have seen repeatedly in the last few years. And it is the perception that "more" is *possible*, even though it has not yet been *achieved*, that stimulates people to examine their own experience, to imagine how they would like services to be, and hence to experiment with alternatives (e.g., alternate institutions, insurgent operation of existing institutions). In the absence of a mass movement to demand better health care, then, the demands stemming from the two modes of criticism of medical care seem opposed. But the opposition is illusory: it disappears in the context of a popular movement.

Finally, it seems to me hard to imagine that any large and

effective movement could develop if it did not emphasize *both* the need for more services *and* the need for a different approach to health altogether. A movement cannot develop if it does not offer people the hope of meeting perceived needs which now go unmet. But if people also perceive that there is something very wrong with even the services that they have, they will not be drawn into a movement that only offers them more of the same. The lack of mass enthusiasm (though not of vague, passive support) for national health insurance is instructive: why should anyone get excited about another bureaucracy to help them pay for services which they know are inadequate? Conversely, would not a movement which held out the vision not of more hospital beds and clinics but of a caring society, not of paying for ever more medical care but of reducing dependency on medical institutions, be infinitely more likely to capture people's imaginations?

Now, imagining the possibility of such a movement, we are led to ask in more detail what the nature of a socialist health system would be. Going back to the political economic and cultural critiques, it is evident that a socialist health system would offer high quality, dignified, readily available health services of all kinds on an equitable basis, regardless of geographic location, race, nationality, or ability to pay. (Although it is beyond my scope here to argue the case fully, if such a system is not to become a bottomless pit for money and to place its institutional priorities ahead of its patients' needs, it must take the form of a decentralized, community- and worker-controlled national health service rather than either national health insurance or a uniform, bureaucratically centralized national health service.) It is equally evident that we cannot talk about a socialist health system that does not deal with the social and environmental causes of bad health. At a minimum (!) this means eliminating poverty, poor housing, poor nutrition, poor schools; eliminating or sharply reducing air and water pollution; and combating unhealthy life styles (e.g., smoking, lack of exercise).

But this does not exhaust our notion of what a socialist (as opposed to a merely socialized) health system would look like. To inquire further, we must peel away the mystification of medical

care imposed by its complex technology and by its historical appearance as a commodity. Medical care is fundamentally a social, not a technical or commercial, relationship. It is embedded in the social relationships of the overall society and expresses the values of the broader society. To ask what kind of medical care we want is, then, to ask some very basic questions about the kind of society that we want to live in. We are left, as we suggested at the beginning of this essay, with the fundamental *social* question of how a good society deals with human *biological* interdependency: with death, birth, pain; with care of the young, the sick, the disabled, and the aged. I should like to conclude this essay by exploring a few of the questions about medical care that such a perspective suggests.

The problem of dependency. The cultural critique focused attention on the way in which the medical system fosters and abuses dependency. To take an extreme case, Ivan Illich has argued that increasing access to medical care would merely increase what he considers socially debilitating individual dependency, and has called for a radical demedicalizing of society; people should learn to cope autonomously with pain, sickness, disability. Illich's demand finds echo in the growing demand by many people for autonomous control over their own bodies, even in situations that doctors would consider deserving of major medical intervention: the number of home deliveries is rising rapidly; the self-help concept spreads; and a variety of health "fads" (e.g., for herbal remedies and massage therapies) have reached epidemic proportions. But, as I have argued above, some, at least, of medical technology is useful and inappropriate for use by untrained people. Rejecting this is, at the very least, a self-destructive form of "autonomy." In any case, the replacement of dependency on doctors with dependency on midwives, friends, and so forth is not a rejection of dependency *per se*; it is a *redirecting* of dependency.

How can the needs for autonomy and dependency be reconciled? The major problem of the medical system now is not that it generates dependency; the problem is the kind of dependency that it generates, and its social impact. What we have to develop is a medical system which acknowledges our need for autono-

mous control over our bodies *and* which accepts our need for dependency; which enhances autonomy but, when we do feel the necessity to give up and be dependent, can deal with that need in a dignified and nurturing way.

More broadly, we might ask whether the medical system should be the major mechanism for dealing with biological dependency. In the last half century or so, the medical system has increasingly assumed this role, taking over from the disintegrating family and community. Any society needs institutions to deal with dependency: the existence of mutual dependency with regard to biological functions is virtually the defining characteristic of human beings as social animals. It is natural, not morbid, that people sometimes need to be taken care of. But is the medical system the right institution to do this? If not, what alternatives are there? Do we imagine that the family, with appropriate social supporting mechanisms, can once again take over the care of the aged, the disabled? How useful, in this context, are images of the family drawn from other times (e.g., the patriarchal extended family of pre-industrial Europe) or from other places (e.g., the contemporary Chinese family, embedded in small, stable communities)? In any case, do we want to concentrate healing and caring in one institution, or spread it out throughout a variety of social institutions?

The problem of professionalism. In order to evolve a health system that is both a curing system and a caring system, we have to confront the problem of professionalism. In our system, professionalism is primarily a defense of status and privilege. Although doctors and other health professionals have defended professionalism as a bulwark of quality, it has functioned more effectively as a mechanism to protect the professionals from scrutiny, to limit access to the occupation and to medical knowledge, and to preserve doctors' control over the health system. To change the health system at all, much less to create a medical system which maximally utilizes self-help and mutual help and which encourages an active rather than a passive role for the patient, will require radical deprofessionalization. We will have to expand radically the use of community health aides; to spread medical knowledge to patients and to nonphysician health workers; to

minimize the social distance between doctors and patients. (I should emphasize that deprofessionalization has nothing to do with eliminating the *skills* of the doctors. Skills are of course needed, and I am not proposing that incompetent people perform medical services—we have too much of that as it is! It is the privileges, the power, and the monopolization of medical knowledge that I am speaking of removing when I speak of deprofessionalization.)

In another sense, however, we have to *re*professionalize medical care. Another of the traditional components of professionalism is the idea that providing health care is a calling, attended by a strong ethic of service. But the result of years of control of the medical system by the doctors in their own narrow self-interest has been the spread of widespread apathy, cynicism, even callousness among nonphysician health workers, who have seen the impossibility of delivering decent health care under our present health system. It seems to me urgent to build a health system in which the idea of health care as a *calling* can be restored. In the context of a capitalist society, however, the idea of selfless caring is considered masochistic. Stating this reemphasizes the magnitude of the social transformation required to have a humane health system: if socialized medicine means health care delivered by callous bureaucracies such as that of so many of our public hospitals and clinics today, we can hardly wonder that it fails to arouse public enthusiasm.

The problem of technology. What part of the technology of modern medicine is salvageable? Recall that a significant proportion of medicine's proudest claims to effectiveness may be false, and that a not insignificant part of modern medical practice may, on net, do more physical harm than good. In any case, in actual practice, much of what doctors do is not based on scientifically validated knowledge. (For instance, a National Academy of Sciences panel, studying the evidence for effectiveness of prescription drugs marketed in the United States in the mid-sixties, found that fully one half of these drugs were either ineffective or ineffective in the form normally prescribed, or at best, "possibly effective.") Doctors, despite their claims to be men of science, widely disregard scientific evidence. (For example, doctors go on

prescribing a drug such as the antibiotic Chloramphenicol in situations where its use is not indicated, despite the availability of alternative drugs and despite the widely publicized and occasionally lethal side effects of the drug.) And doctors, with rare exceptions, have been completely unable to recognize, much less deal with, the interactions of mind and body, environment and body, society and body.

The question, then, is not one of throwing out scientific medicine; it is a question of whether medicine can *become* a science. This, in turn, raises questions about the basic assumptions of science (in the sense of physics, chemistry, biology): the traditional natural sciences objectify the things that they study; they have no place for consciousness or subjectivity. But human beings are conscious creatures; as I have repeatedly emphasized, the healing relationship is not merely physiological, but also social. Are biology and chemistry and physics an adequate, appropriate, and complete basis for a science of healing human beings? If not, what is the basis (or what are the limitations) of scientific medicine? The conditions of medical practice in capitalist society have not permitted this question to be raised seriously.

Medicine as a social endeavor. In repudiating our present dependency on institutionalized medicine for all aspects of health care, it would be easy to embrace the opposite extreme—medical anarchy: notions of rationality in determining methods of care, of discipline in obtaining and using skills, of belief in medical authority would be discarded; what feels good, physically or psychologically, would become the arbiter of the kind of medical care that one would seek. Already signs of such a revolt against medicine as a rational and social endeavor abound, evidenced for example in the booming demand for almost certainly useless drugs such as Laetrile, and in the widespread reliance on home remedies for serious and readily treatable ailments. (The irony is great: the same people who berate the drug companies for their lack of testing or their false advertising of drugs embrace and extol the value of totally untested herbal remedies.)*

* In China, where efforts to inculcate rationalist, scientific modes of thinking in people are a high priority, a high-ranking health official told me that he regarded

How, then, do we reconcile notions of individual freedom and dignity with a rational and social approach to healing technology? Should people have the right to do whatever they want to their bodies? (For example, should the prescription system be abolished and all drugs be freely available over the counter?) Should practitioners have the right to treat illnesses in whatever manner they deem appropriate, and should patients have the right to choose anyone claiming to be a practitioner to treat them? If not, who should determine who is a competent healer and who is not? Other healers? Patients? Using what criteria?

Questions such as these make it clear that the problems of health and medicine cannot be treated as problems of technique, of administration, of distribution, separate from the overall problems of social values and the institutional arrangements by which the dominant classes in a society express their values. Even a brief effort at trying to define a socialist medicine reveals that questions of health policy are not narrow questions of how to reform the health system; they are among the most profound questions that we can ask about the society in which we live.

The essays in Part 1 explore the social functions of medicine from a theoretical point of view. Barbara and John Ehrenreich focus on the nature and consequences of the interaction between an individual doctor and his or her patients. Irving Zola examines why medicine has replaced institutions such as the family and the church as a mechanism of social control and discusses the political consequences of the "medicalization" of social problems. Marc Renaud locates some of the limitations of modern medicine in the models of human health and disease evolved by capitalist societies since the late nineteenth century.

Parts 2 and 3 are more empirical, providing together two case studies in the themes developed theoretically in Part 1. In Part 2 (Medicine and Women), Barbara Ehrenreich and Deirdre English sketch historically the role of doctors in controlling women's lives. Linda Gordon traces how one particular part of the technology associated with the control of women's lives—birth

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double blind procedures for testing drugs and controlled studies of the relative effectiveness and the side effects of drugs for the same illness as "bourgeois" notions, reflecting drug companies' competitive interests. I was not convinced.

control—began to be taken out of women's hands and placed under physicians' control. Doris Haire argues that current medical approaches to childbirth in the United States have little basis in science; they are culturally, rather than technically, determined procedures. Mary Howell and Diana Scully and Pauline Bart suggest that doctors' sexist attitudes toward women pervade the medical literature and are inculcated in young doctors by their textbooks (among other means), with no regard for their scientific validity.

In Part 3 (Medicine and Imperialism), Frantz Fanon provides a classic description of how the overall social relations between an oppressor and an oppressed group pervade the medical interaction between doctors (belonging to the oppressor group) and patients (belonging to the oppressed group). Fanon's example is colonial Algeria, but his comments would apply equally well to blacks in the United States, to women, and to other oppressed groups. James Paul and E. Richard Brown discuss the historical uses of medicine in advancing U.S. and European imperialism. And Howard Levy describes the direct role that medicine came to play in the U.S. effort to suppress the revolutionary struggle in Vietnam. (Dr. Levy, many readers may recall, was jailed for two years for his refusal to teach Green Berets medical tricks to help "pacify" the Vietnamese.)

NOTES

1. See, for example, Committee on the Costs of Medical Care, *Medical Care for the American People* (Chicago: University of Chicago Press, 1932; reprinted by the U.S. Dept. of Health, Education, and Welfare, Washington, D.C., 1970). More recent examples include Edward M. Kennedy, *In Critical Condition* (New York: Simon & Schuster, 1972); Abraham Ribicoff with P. Danaceau, *The American Medical Machine* (New York: Saturday Review Press, 1972); Ed Cray, *In Failing Health* (Indianapolis and New York: Bobbs-Merrill, 1970).
2. See Barbara and John Ehrenreich, *The American Health Empire: Power, Profits, and Politics* (A Health-PAC book; New York: Random House, 1970); *Billions for Bandaids*, ed. T. Bodenheimer, S. Cummings, and E. Harding (San Francisco: Medical Committee for Human Rights, 1972); *Prognosis Negative: Crisis in the Health Care*

System, ed. David Kotelchuck (A Health-PAC book; New York: Vintage, 1976); Vicente Navarro, *Medicine Under Capitalism* (New York: Prodist, 1976). Navarro argues that it is not private ownership per se but the institutional and ideological subordination of the health sector to the ruling classes of American capitalism which determine the characteristics of American medicine.

3. See Henry E. Sigerist, "Socialized Medicine," *The Yale Review* (Spring 1938), reprinted in *National Health Care*, ed. Ray H. Elling (New York: Lieber-Atherton, 1973); Milton Roemer, "Nationalized Medicine for America," *Trans-Action* (September 1971); Medical Committee for Human Rights, "Preliminary Position Paper on National Health Care" (September 1971), reprinted by Congressman Ron V. Dellums in *Congressional Record*, vol. 117, no. 199, part III, December 17, 1971.
4. H. J. Eysenck, "Effects of Psychotherapy," *International Journal of Psychiatry* 1 (1965): 97-198; also, Philip R. A. May, *Treatment of Schizophrenia* (New York: Science House, 1968), esp. pp. 47-52; and L. Grinspoon, J. R. Ewalt, and R. Shader, "Psychotherapy and Pharmacotherapy in Chronic Schizophrenia," *American Journal of Psychiatry* 124 (1968): 1645-52.
5. R. D. Laing, "The Obvious," in *Going Crazy*, ed. Hendrik M. Ruitenbeck (New York: Bantam Books, 1972), p. 113.
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