Medical Nemesis: The Expropriation of Health (1976)

Ivan Illich, 1926-2002 (http://en.wikipedia.org/wiki/Ivan_Illich)

Introduction: The medical establishment has become a major threat to health. The disabling impact of professional control over medicine has reached the proportions of an epidemic.

Thoughtful public discussion of the iatrogenic ["physician caused", **iatros**=physician & **genus**=birth] pandemic, beginning with an insistence upon demystification of all medical matters, will not be dangerous to the commonweal. Indeed, what is dangerous is a passive public that has come to rely on superficial medical housecleaning.

My argument is that the layman and not the physician has the potential perspective and effective power to stop the current iatrogenic pandemic.
During the last generations the medical monopoly over health care (HC) has expanded without checks and has encroached on our liberty with regard to our own bodies. Society has transferred to physicians the exclusive right to determine what constitutes sickness, who is or might become sick, and what shall be done to such people...The social commitment to provide to all citizens with almost unlimited outputs from the medical system threatens to destroy the environmental and cultural conditions needed by people to live a life of constant autonomous healing. [see: http://en.wikipedia.org/wiki/Iatrogenesis]

Limits to medicine must be something other than professional self-limitation... the insistence of the medical guild on its unique qualifications to cure medicine itself is based on an illusion.
It must be understood that what has turned HC into a sick-making enterprise is the very intensity of an engineering endeavor that has translated human survival from the performance of organisms into the result of technical manipulation.

Built-in iatrogenesis now affects all social relations. It is the result of internalized colonization of liberty by affluence. In rich countries medical colonization has reached sickening proportions and poor countries are quickly following suit (*today, drug companies, hospitals and insurance companies have joined physicians in the expropriation of health -- DJE)* Illich calls this "the medicalization of health."

Part I: Clinical Iatrogenesis
Chapter 1 The Epidemics of Modern Medicine
During the past three generations the diseases afflicting Western societies have undergone dramatic changes...These changes in health status are generally equated with a decrease in suffering and attributed to more or to better medical care. There is in fact no evidence of any direct relationship between this mutation of sickness and the so-called progress of medicine.
A vast amount of contemporary clinical care is incidental to the curing of disease, but the damage done by medicine to the health of populations is very significant.

During the 20th C doctors have affected epidemics no more profoundly than priests during earlier times.
The professional practice of physicians cannot be credited with the elimination of old forms of mortality and morbidity, nor should it be blamed for the increased life-expectancy [many experience] suffering from new diseases.
One-third of humanity survives on a level of undernourishment which would formerly be called lethal, while more and more rich people absorb ever greater amounts of poisons and mutagens in their foods.
In contrast to the environmental improvements and modern nonprofessional health measures, the specifically medical treatment of people is never significantly related to a decline in the compound disease burden or to a rise in life expectancy. Neither the proportion of doctors in a population nor the clinical tools at their disposal nor the number of hospital beds is a causal factor in the striking changes in overall patterns of disease.
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 activities, and make the impact of medicine one of the most rapidly spreading epidemics of our time. (Gawande in "Checklist Manifesto" 2009 tells us that upwards of 150,000 deaths follow surgery in the U.S. every year. This is three times the number of people that die in road traffic accidents. p. 31)
With the transformation of the doctor from an artisan exercising a skill on personally known individuals into a technician applying scientific rules to classes of patients, malpractice acquired an anonymous, almost respectable, status.
It has been established that one of every five patients admitted to a typical research hospital acquires an iatrogenic disease which in one of thirty cases leads to death. Despite good intentions and claims to public service a military officer with a similar record of performance would be relieved of his command, and a restaurant or amusement center would be closed by the police.
On a second level, medical practice sponsors sickness by reinforcing a morbid society that encourages people to become consumers of curative, preventive, industrial and environmental medicine.
On a third level, the so-called "health professions" have an even deeper, culturally health-denying effect insofar as they destroy the potential of people to deal with their human weakness, vulnerability, and uniqueness in a personal and autonomous way.
Illich calls the self-reinforcing loop of negative institutional feedback by its classical Greek equivalent: "*medical nemesis*."
Medical nemesis is resistant to medical remedies. It can be reversed only through a recovery of the will to self-care among the laity, and through the legal, political and institutional recognition or the right to care.

Part II: Social Iatrogenesis
2. The Medicalization of Life

Social iatrogenesis designates a category of etiology that encompasses many forms. It obtains when medical bureaucracy creates ill-health by increasing stress, by multiplying disabling dependence, by generating new painful needs, by lowering the levels of

tolerance for discomfort or pain, by reducing the leeway that people are wont to concede to an individual when he suffers, and by abolishing even the right to self-care. [It turns] the language in which people could experience their bodies into bureaucratic gobbledygook; or when suffering, mourning, and healing outside the patient role are labeled a form of deviance.
The malignant spread of medicine has turned mutual care and self-medication into misdemeanors or felonies.
Iatrogenic medicine reinforces a morbid society in which social control of the population by the medical system turns into a principal economic activity.
Medical specialists form professions which exercise a unique kind of control over their own work. Unlike unions, these professions owe their autonomy to a grant of confidence rather than to a victory in a struggle. Unlike guilds, which determine only who shall work and how, they determine also what work shall be done. The medical profession is a manifestation in one particular sector of the control over the structure of class power which the university-trained elites have acquired. Only doctors "know" what constitutes sickness, who is sick, and what shall be done to those whom they consider *at a special risk.*
The divorce between medicine and morality has been defended on the ground that medical categories, unlike those of law and religion, rest on scientific foundations exempt from moral evaluation.

The most handy measure of the medicalization of life is the share taken out of a typical yearly income to be spent under doctors orders. **[This is a key section and is called: "The Medicalization of the Budget.]**
The phenomenal rise in the cost of "health services" in the U.S. has been explained in different ways; some blame irrational planning, others the higher cost of the new gimmicks that people want in hospitals.
The proportion of national wealth which is channeled to doctors and expended under their control varies from one nation to another and falls somewhere between 1/10 and 1/20 of all available funds. [Now in the U.S. it is 1/6th -- or two months of work!]
Excepting only the money allocated for treatment of water supplies, 90% of all funds earmarked for health in developing countries is sip not for sanitation but for treatment of the sick. From 70 - 80% of the entire public health budget goes to the cure and care of individuals as opposed to public health services.
All countries want hospitals and want them to have the most modern exotic equipment. The prestige of a puny national team in the medical Olympics is used to intensify a nationwide addiction to therapeutic relationships that are pathogenic on a level much deeper than mere medical vandalism. More health damage is caused by people's belief that they cannot cope with their illness unless they call a doctor than doctors could ever cause by foisting their ministrations on people.
Each culture has its remedies, its placebos, and its ritual settings for their administration. Most of these are destined for the healthy rather than the sick. Powerful medical drugs...usually cause more damage than profit to health, and ultimately establish the belief that the body is a machine run by mechanical and manipulating switches.
Surprisingly, the per capita use of medically prescribed drugs around the world seems to have little to do with commercial promotion; it correlates mostly with the number of

doctors, even in socialist countries where the education of the physicians is not influenced by drug industry publicity and where corporate drug-pushing is limited... In all countries, doctors work increasingly with two groups of addicts: those for whom they prescribe drugs, and those who suffer from their consequences. The richer the community, the larger percentage of patients who belong to both.

The current pattern of the over-consumption of drugs can be understood as a pattern consistent with the ideology of any society oriented towards open-ended enrichment, regardless whether its industrial product is meant for distribution by the presumption of planners or by forces of the market. People come to believe that technology can be used to change the human condition...

The age of new drugs began with aspirin in 1899. Before that time, the doctor himself was without dispute the most important therapeutic agent.

The fallacy that society is caught forever in the drug age is one of the dogmas with which medical policy-making has been encumbered: it fits industrialized man. He has learned to try to purchase whatever he fancies. He gets nowhere without transportation or education; his environment has made it impossible for him to walk, to learn, and to feel in control of his body. To take a drug, no matter which and for what reason -- is a last chance to assert control over himself, to interfere on his own with his body rather than to let others interfere. The pharmaceutical invasion leads him to medication, by himself or by others, that reduces his ability to cope with a body for which he can still care.

Once a society is so organized that medicine can transform people into patients b/c they are unborn, newborn, menopausal, or at some other "age of risk" the population inevitably loses some obits autonomy to its healers.

Lifelong medical supervision...turns life into a series of periods of risk, each calling for tutelage of a special kind. From the crib to the office and from the Club Med to the terminal ward, each age-cohort is conditioned by a milieu that defines health for those whom it segregates.

For rich and poor, life is turned into a pilgrimage through check-ups and clinics back to the ward where it started. At each stage of their lives people are age-specifically disabled. The old are the most obvious example: they are victims of treatments meted out for an incurable condition.

In the rich countries the life expectancy of those between 15 and 45 has tended to stabilize because accidents and new diseases of civilization kill as many as formerly succumbed to pneumonia and other infections.

As more of the elderly acquire rights to professional care, opportunities for independent aging decline. More have to seek refuge in institutions.

While it has become acceptable to advocate limits to the escalation of costly care for the old, limits to so-called medical investments in childhood are still a subject that seems taboo. Industrial parents, forced to procreate manpower for a world into which nobody fits who has not been crushed and molded by 16 years of formal education, feel impotent to care personally for their offspring and, in despair, shower them with medicine.

Preventive Stigma

As curative treatment focuses increasingly on conditions in which it is ineffectual, expensive, and painful, medicine has begun to market prevention. The concept of morbidity has been enlarged to cover prognosticated risks. Along with sick-care, health has become a commodity, something one pays for rather than something one does....

Patients are turned into patients w/o being sick. The medicalization of prevention thus becomes another major symptom pf social iatrogenesis. The word "check-up" has entered French, Serbian, Spanish, Malay and Hungarian dictionaries.
With regards to multiphasic testing, two dozen studies indicate that these diagnostic procedures **have no positive impact on life-expectancy.** Ironically, the serious asymptomatic disorders which this kind of screening alone can discover among adults are frequently incurable illnesses in which early treatment only aggravates the patent's physical condition. In any case, it transforms people who feel healthy into patients anxious for their verdict.
Routine performance of early diagnostic tests on large populations guarantees the medical scientist (practitioner) a broad base from which to select the cases that best fit existing treatment facilities or are most useful in the attainment of research goals, whether or not the therapies cure, rehabilitate, or soothe. In the process, people are strengthened in their belief that they are machines whose durability depends on visits to the maintenance shops, and are thus not only obliged but also pressured to foot the bill for the market research and the sales activities of the medical establishment.
Diagnosis always intensifies stress, defined incapacity, imposes inactivity, and focuses apprehension on non-recovery, on uncertainty, and on one's dependence
u[on future medical findings, all of which amounts to a loss of autonomy for self-definition... Once a society organizes for a preventive disease-hunt, it gives epidemic proportions to diagnosis. The ultimate triumph of therapeutic culture turns the independence of the average healthy person into an intolerable form of deviance.

Terminal Ceremonies
Therapy reaches its apogee in the death-dance around the terminal patient. At a cost of between $500 - 2000 per day [and this was in 1975] celebrants in white and blue envelope what remains of the patient in antiseptic smells.
The conjuring doctor perceives himself as a manager of crisis. In an insidious way he provides each citizen at the last hour with an encounter with society's deadening dream of infinite power. Like any crisis manager of state, bank or couch, he plans self-defeating strategies and commandeers resources which, in their uselessness and futility, seem all the more grotesque. At the last moment he promises to each patient that claim on absolute priority for which most people regard themselves as too unimportant.
Hospital death is now endemic. Death without medical presence becomes synonymous with romantic pigheadedness, privilege or disaster. The cost of a citizen's last days has increased an estimated 1200%, much faster than that of overall health-care.
The modern fear of unhygenic death makes life appear like a race towards a terminal scramble and has broken personal self-confidence in a unique way. It has fostered the belief that man today has lost the autonomy to recognize when his time has come and to take his death into his own hands. The doctor's refusal to recognize the point at which he has ceased to be useful as a healer and to withdraw when death shows on his patient's face has made him into an agent f evasion or outright dissimulation.
Like any other growth industry, the health care system directs its products where demand seems unlimited: into defense against death. The patient-elect is conditioned to desire the "scarce" privilege of dying in exquisite torture.

Black Magic

Technical intervention in the physical and biochemical make-up of the patient or of his environment is not, and never has been, the sole function of medical institutions. The removal of pathogens and the application of remedies (effective or not) are by no means the sole way of mediating between man and his disease. Even in those circumstances in which the physician is technically equipped to play the technical role to which he aspires, he inevitably also fulfills religious, magical, ethical and political functions. IN each of these functions the contemporary physician is more pathogen than healer or just anodyne.

Among the important nontechnical functions of medicine is the ethical one, secular not religious. Medicine can be so organized that it motivates the community to deal in a more or less personal fashion with the frail, the decrepit, the tender, the crippled, the depressed, and the manic. By fostering a certain type of social character, a society's medicine could effectively lessen the suffering of the diseased by assigning an active role to all members of the community in the compassionate tolerance for and the selfless assistance to the weak. [The Quran says something similar: "No blame is there upon the blind, nor any blame upon the lame, nor any
blame upon the sick...and as for the insane, feed and clothe them, and speak kindly to them." quoted by Mike LaCombe.]

Healers can be priests of the gods, lawgivers, magicians, mediums, barber-pharmacists, or scientific advisors. No common name with even the semantic range covered by our "doctor" existed in Europe before the 14th C...The first occupation to monopolize health care is that of the physician of the late 20th C.

The less proof there is that more money increases survival rates in a given branch of cancer treatment, the more money will go to the medical divisions deployed in that special theater of operations.

Medical miracle treatments (such as heart transplantation have worldwide impact and provides people with an abstract assurance that salvation through science is possible. Medical procedures turn into *black magic* when, instead of mobilizing one's self-healing powers, they transform the sick individual into a limp and mystified voyeur of his own treatment. Medical procedures turn into *sick religion* when they are performed as rituals that focus the entire expectation of the sick on science and its functionaries instead of encouraging them to seek a poetic interpretation of their predicament... Medical procedures [like colonoscopies, mammograms, skin exams] multiply disease by *moral degradation* when they isolate the sick in a professional environment rather than providing society with the motives and disciplines that increase social tolerance for the troubled.

Patient Majorities

Whenever medicine's diagnostic power multiplies the sick in excessive numbers, medical professionals turn over the surplus to the management of nonmedical trades and occupations.

Only medicine knows what constitutes addiction, though policemen are supposed to know how it should be controlled. Only medicine can define brain damage, but it allows teachers to stigmatize and manage the healthy looking cripples.

Each civilization defines its own diseases. What is sickness in one might be chromosomal abnormality, crime, holiness, or sin in another.

The role of the doctor has now become blurred. The health professions have come to combine clinical service, public-health engineering, and scientific medicine.
Previously modern medicine controlled only a limited market; now this market has lost all boundaries. Unsick people have come to depend on professional care for the sake of their future health. The result is a morbid society that demands universal medicalization and a medical establishment that certifies universal morbidity.
With the development of the therapeutic service sector of the economy, an increasing proportion of all people come to be perceived as deviating from some desirable norm, and therefore as clients who can now either be submitted to therapy to bring them closer to the established standard of health of concentrated into some special environment built to cater their deviance.
When he assigns sick-status to a client, the contemporary physician might indeed be acting in some ways similar to the sorcerer or the elder; but in belonging also to a scientific profession that *invents* the categories it assigns when consulting, the modern physician is totally unlike the healer.
But the sick-role designed by Parsons fits modern society only as long as doctors act as if treatment were usually effective and while the general public is willing to share their rosy view.
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In a morbid society the belief prevails that defined and diagnosed ill-health is infinitely preferable to another form of negative label or to no label at all.
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Part III - Cultural Iatrogenesis

Introduction

Cultural iatrogenesis represents a third dimension of medical health-denial. It sets in when the medical enterprise system saps the will of people to suffer their reality.
Professionally organized medicine has come to function as a domineering moral enterprise that advertises industrial expansion as a war against all suffering. It has thereby undermined the ability of individuals to face their reality, to express their own values, and to accept inevitable and often irremediable pain and impairment, decline, and death.
All traditional cultures derive their hygienic function from this ability to equip the individual with the means for making pain tolerable, sickness or impairment understandable, and the shadow of death meaningful.
The ideology promoted by contemporary cosmopolitan medical enterprise runs counter to these functions. It radically undermines the continuation of old cultural programs and

prevents the emergence of new ones that would provide a pattern for self-care and suffering.
Medical civilization is planned and organized to kill pain, to eliminate sickness, and to abolish the need for an art of suffering and of dying.
Suffering, healing, and dying, which are essentially intransitive activities that culture taught each man, are now claimed by technocracy as new areas of policy-making and are treated as malfunctions from which populations ought to be institutionally relieved. The goals of metropolitan medical civilization are thus in opposition to every single cultural health program they encounter in the process of progressive colonization.

3 – The Killing of Pain

Medical civilization, however, tends to turn pain into a technical matter and thereby deprives suffering of its inherent personal meaning. People unlearn the acceptance of suffering as an inevitable part of their conscious coping with reality and learn to interpret every ache as an indicator of their need for padding or pampering.
Culture makes pain tolerable by interpreting its necessity; only pain perceived as curable is intolerable.
In every traditional culture the psychotherapy, belief systems, and drugs needed to withstand most pain are built into everyday behavior and reflect the conviction that reality is harsh and death is inevitable.
The experience of pain that results from pain messages received by the brain depends on its quality and in its quantity on genetic endowment and on at least four functional factors other than the nature and intensity of the stimulus: namely culture, anxiety, attention, and interpretation.
Like Oliver Wendell Holmes, the good doctor who knew that nature provided better remedies for pain than medicine could say "[with the exception of] opium, which the Creator himself seems to prescribe, for we often see the scarlet poppy growing in the cornfield as if it were foreseen that wherever there is hunger to be fed there must also be pain to be soothed; [with the exception of] a few specifics which our doctor's art did not discover; [with the exception of] wine, which is a food, and the vapours which produce the miracle of anaesthesia . . . I firmly believe that if the whole *materia medica,* as now used, could be sunk to the bottom of the sea, it would be all the better for mankind – and all the worse for the fishes."
As an alchemic doctor put it in the sixteenth century, pain is the "bitter tincture added to the sparkling brew of the world's seed."
Opium, acupuncture, or hypnosis, always in combination with language, ritual, and myth, was applied to the unique human performance of *suffering pain.*
There were three reasons why the idea of professional, technical pain-killing was alien to all European civilizations.
The campaign against pain as a personal matter to be understood and suffered got under way only when body and soul were divorced by Descartes. He constructed an image of the body in terms of geometry, mechanics, or watchmaking, a machine that could be repaired by an engineer. The body became an apparatus owned and managed by the soul, but from an almost infinite distance.
For Descartes pain became a signal with which the body reacts in self-defense to protect its mechanical integrity.

In this context it now seems rational to flee pain rather than to face it, even at the cost of giving up intense aliveness. It seems reasonable to eliminate pain, even at the cost of losing independence. It seems enlightened to deny legitimacy to all nontechnical issues that pain raises, even if this means turning patients into pets. With rising levels of induced insensitivity to pain, the capacity to experience the simple joys and pleasures of life has equally declined. Increasingly stronger stimuli are needed to provide people in an anesthetic society with any sense of being alive. Drugs, violence, and horror turn into increasingly powerful stimuli that can elicit an experience of self. Widespread anesthesia increases the demand for excitation by noise, speed, violence – no matter how destructive.

4 – The Invention and Elimination of Disease

The French Revolution gave birth to two great myths: one, that physicians could replace the clergy; the other, that with political change society would return to a state of original health. Sickness became a public affair. In the name of progress, it has now ceased to be the concern of those who are ill.

The hospital, which at the very beginning of the nineteenth century had become a place for diagnosis, was now turned into a place for teaching. Soon it would become a laboratory for experimenting with treatments, and towards the turn of the century as a place concerned with therapy. Today the pesthouse has been transformed into a compartmentalized repair shop.

The age of hospital medicine, which from rise to fall lasted no more than a century and a half, is coming to an end. Clinical measurement has been diffused throughout society. Society has become a clinic, and all citizens have become patients whose blood pressure is constantly being watched and regulated to fall "within" normal limits. The acute problems of manpower, money, access, and control that beset hospitals everywhere can be interpreted as symptoms of a new crisis in the concept of disease.

All disease is a socially created reality. Its meaning and the response it has evoked have a history. The study of this history will make us understand the degree to which we are prisoners of the medical ideology in which we were brought up.

An advanced industrial society is sick-making because it disables people from coping with their environment and, when they break down, substitutes a "clinical," or therapeutic, prosthesis for the broken *relationships*. People would rebel against such an environment if medicine did not explain their biological disorientation as a defect in their health, rather than as a defect in the way of life which is imposed on them or which they impose on themselves.

In every society the classification of disease – the nosology – mirrors social organization. The sickness that society produces is baptized by the doctor with names that bureaucrats cherish. "Learning disability," "hyperkinesis," or "minimal brain dysfunction" explains to parents why their children do not learn, serving as an alibi for school's intolerance of incompetence; high blood pressure serves as an alibi for muting stress, degenerative disease for degenerating social organization. The more convincing the diagnosis, the more valuable the therapy appears to be, the easier to convince people that they need both, and the less likely they are to rebel against industrial growth. Unionized workers demand the most costly therapy possible, if for no reason than the perverse leisure of

getting back some of the money they have put into taxes and insurance, and deluding themselves that this will create more equality.
Before sickness came to be perceived primarily as an organic or behavioral abnormality, he who got sick could still find in the eyes of the doctor a reflection of his own anguish and some recognition of the uniqueness of his suffering. Now, what he meets is the gaze of a biological accountant engaged in input/output calculations. His sickness is taken from him and turned into the raw material for an institutional enterprise.
Language is taken over by the doctors: the sick person is deprived of meaningful words for his anguish, which is thus further increased by linguistic mystification.
Proverbs and sayings kept instructions readily available.
Finally, increasing dependence of socially acceptable speech on the special language of an elite profession makes disease into an instrument of class domination. The university-trained and the bureaucrat thus become their doctor's colleague in the treatment he dispenses, while the worker is put in his place as a subject who does not speak the language of his master.
As soon as medical effectiveness is assessed in ordinary language, it immediately appears that most effective diagnosis and treatment do not go beyond the understanding that any layman can develop. In fact, the overwhelming majority of diagnostic and therapeutic interventions that demonstrably do more good than harm have two characteristics; the material resources for them are extremely cheap, and they can be packaged and designed for self-use of application by family members.
They would hardly be valid in a world that aimed at the effective pursuit of personal goals that an austere use of technology had put within the range of almost everyone.

5 – Death Against Death
The image of a "natural death," a death which comes under medical care and finds us in good health and old age, is a quite recent ideal.
In five hundred years it has evolved through five distinct stages, and is now ready for a sixth.
1. The Devotional Dance of the Dead
2. The Danse Macabre
Of course, once death had become such a natural force, people wanted to master it by learning the art or the skill of dying. *Ars Moriendi*, one of the first printed do-it-yourself manuals on the market, remained a best-seller in various versions for the next two hundred years.
3. Bourgeois Death
However, with the rise of the bourgeois family, equality in death came to an end: those who could afford it began to pay to keep death away.
Francis Bacon was the first to speak about the prolongation of life as a new task for physicians.
In the years just before the French Revolution this had become the health of the rich and the powerful; within a generation chronic disease became fashionable for the young and pretentious, consumptive features the sign of premature wisdom, and the need for travel into warm climates a claim to genius.
By contrast, a reverse judgment now could be made on the ailments of the poor, and the ills from which they had always died could be defined as untreated sickness.

4. Clinical Death

A number of book plates from private libraries of late nineteenth-century physicians show the doctor battling with personified diseases at the bedside of his patient. The hope of doctors to control the outcome of specific diseases gave rise to the myth that they had power over death. The new powers attributed to the profession gave rise to the new status of the clinician.

5. Trade Union Claims to a Natural Death

In our century a valetudinarian's death while undergoing treatment by clinically trained doctors came to be perceived, for the first time, as a civil right. Old-age medical care was written into union contracts. The capitalist privilege of natural extinction from exhaustion in a director's chair are way to the proletarian demand for health services during retirement.

Lifelong care for every clinical condition soon became a peremptory demand for access to a natural death. Lifelong institutional medical care had become a service that society owed all its members.

First of all, this new image of death endorses new levels of social control. Society has become responsible for preventing each man's death: treatment, effective or not, can be made into a duty. Any fatality occurring without medical treatment is liable to become a coroner's case.

Our new image of death also befits the industrial ethos. The good death has irrevocably become that of the standard consumer of medical care. Just as at the turn of the century all men were defined as pupils, born into original stupidity and standing in need of eight years of schooling before they could enter productive life, today they are stamped from birth as patients who need all kinds of treatment if they want to lead life the right way. When the doctor contrived to step between humanity and death, the latter lost the immediacy and intimacy gained four hundred years earlier. Death that had lost face and shape had lost *its* dignity.

We have to wait until after World War I before we see physicians wrangling with the skeleton, tearing a young woman from its embrace, and wresting the scythe from death's hand.

Now the doctor rather than the patient struggles with death. As in primitive cultures, somebody can again be blamed when death triumphs.

The culprit might be the class enemy who deprives the worker of sufficient medical care, the doctor who refuses to make a night visit, the multinational concern that raises the price of medicine, the capitalist or revisionist government that has lost control over its medicine men, or the administrator who partly trains physicians at the University of Delhi and then drains them off to London. The witch-hunt that was traditional at the death of a tribal chief is being modernized. For every premature or clinically unnecessary death, somebody or some body can be found who irresponsibly delayed or prevented a medical intervention.

6. Death Under Intensive Care

Curiously, death became the enemy to be defeated at precisely the moment at which megadeath came upon the scene. Not only the image of "unnecessary" death is new, but also our image of the end of the world. Death, the end of *my* world, and apocalypse, the end of *the* world, are intimately related; our attitude towards both has clearly been deeply affected by the atomic situation.

Instead of being due to the will of God, or man's guilt, or the laws of nature, Armageddon has become a possible consequence of man's direct decision.
In many a village in Mexico, I have seen what happens when social security arrives. For a generation people continue in their traditional beliefs; they know how to deal with death, dying, and grief. The new nurse and the doctor, thinking they know better, teach them about an evil pantheon of clinical deaths, each one of which can be banned, at a price. Instead of modernizing people's skills for self-care, they preach the ideal of hospital death. By their ministration they urge the peasants to an unending search for the good death of international description, a search that will keep them consumers forever.
Through the modernization of death, health care has become a monolithic world religion whose tenets are taught in compulsory schools and whose ethical rules are applied to a bureaucratic restructuring of the environment: sex has become a subject in the syllabus and sharing one's spoon is discouraged for the sake of hygiene.
Only a culture that evolved in highly industrialized societies could possibly have called forth the commercialization of the death-image that I have just described.
Socially approved death happens when man has become useless not only as a producer but also as a consumer. It is the point at which a consumer, trained at great expense, must finally be written off as a total loss. Dying has become the ultimate form of consumer resistance.
Today, man most protected against setting the stage for his own dying is the sick person in critical condition. Society, acting through the medical system, decides when and after what indignities and mutilations he shall die.
Technical death has won its victory over dying. Mechanical death has conquered and destroyed all other deaths.

Part IV - The Politics of Health

6 - Specific Counterproductivity

Iatrogenesis will be controlled only if it is understood as but one aspect of the destructive dominance of industry over society, as but one instance of that paradoxical counterproductivity which is now surfacing in all major industrial sectors. Like time-consuming accelraration, stupefying education, self-destructive military defense, disorienting information, or unsettling housing projects, pathogenic medicine is the result of industrial overproduction that paralyzes autonomous action.
Negative externality is the name of the social costs that are not included in the monetary price; it is the common designation for the burdens, privations, nuisances, and injuries that I impose on others by each passenger-mile I travel.
Counterproductivity is something other than either an individual or social cost; it is distinct from the declining utility obtained for a unit of currency and from all forms of external disservice.
This specific counterproductivity constitutes an unwanted side-effect of industrial production which cannot be externalized from the particular economic sector that produces it. Fundamentally, it is due neither to technical mistakes nor to class exploitation but to industrially generated destruction of those environmental, social, and psychological conditions needed for the development of nonindustrial or nonprofessional use-values.

In such an industrialized society, people are conditioned *to get* things rather than *to do* them; they are trained to value what can be purchased rather than what they themselves can create. They want to be taught, moved, treated, or guided rather than to learn, to heal, and to find their own way.

Healing ceases to be considered a task for the sick. It first becomes the duty of the individual body repairmen, and then soon changes from a personal service into the output of an anonymous agency.

Schools produce education, motor vehicles produce locomotion, and medicine produces health care. These outputs are staples that have all the characteristics of commodities. Like school education and motor transportation, clinical care is the result of a capital-intensive commodity production; the services produced are designed for others, not with others nor for the producer.

Owing to the industrialization of our world-view, it is often overlooked that each of these commodities still competes with a nonmarketable use-value that people freely produce, each on his own. People learn by seeing and doing, they move on their feet, they heal, they take care of their health, and they contribute to the health of others.

Effective sick-care depends on the degree to which pain and dysfunction are made tolerable and recovery is enhanced. The effective satisfaction of these needs must be clearly distinguished from the efficiency with which industrial products are made and marketed from the number of certificates, passenger-miles, housing units, or medical interventions performed.

The social criteria by which effective need-satisfaction can be evaluated do not match the measurements used to evaluate the production and marketing of industrial goods.

The invasion of the underdeveloped countries by new instruments of production organized for financial efficiency rather than local effectiveness and for professional rather than lay control inevitably disqualifies tradition and autonomous learning and creates the need for therapy from teachers, doctors, and social workers. While road and radio mold the lives of those whom they reach to industrial standards, they degrade their handicrafts, housing, or health care much faster than they crush the skills they replace.

When perception of personal needs is the result of professional diagnosis, dependence turns into a painful disability. The aged in the United States can again serve as the paradigm.

Having learned to consider old age akin to disease, they have developed unlimited economic needs in order to pay for interminable therapies, which are usually ineffective, are frequently demeaning and painful, and cal more often than not for reclusion in a special milieu.

Five faces of industrially modernized poverty appear caricatured in the pampered ghettos of rich men’s retirement.

1. The incidence of chronic disease increases as fewer people die in their youth
2. More people suffer clinical damage from health measures
3. Medical services grow more slowly than the spread of urgency and demand
4. People find fewer resources in their environment and culture to help them come to terms with their suffering, and thus are forced to depend on medical services for a wider range of trivia.
5. People lose the ability to live with impairment or pain and become dependent on the management of every discomfort by specialized service personnel

7 – Political Countermeasures

In the early 1960s, the British National Health Service still enjoyed a worldwide reputation particularly among American reformers.

Nor had the health planners forecast that the threshold of tolerance for everyday reality would decline as fast as the competence for self-care was undermined, and that one-quarter of all visits to the doctor for free service would be for the untreatable common cold.

The sixties also witnessed the rise and fall of a multinational consortium for the export of optimism to the third world which took shape in the Peace Corps, the Alliance for Progress, Israeli aid to Central Africa, and in the last brush-fires of medical-missionary zeal. The Westerns belief that its medicines could cure the ills of the nonindustrialized tropics was then at its height.

The class-specific nature of body perception, language, concepts, access to health services, infant mortality, and actual, specifically chronic, morbidity has been widely documented, and the class-specific origins and prejudices of physicians are beginning to be understood.

Patients are starting to listen, and a growing number of movements and organizations are beginning to demand reform. The attacks are founded on five major categories of criticism and are directed to five categories of reform:

1. Production of remedies and services has become self-serving. Consumer lobbies and consumer control of hospital boards should therefore force doctors to improve their wares.
2. The delivery of remedies and access to services is unequal and arbitrary; it depends either on the patient's money and rank, or on social and medical prejudices which favor, for example, attention to heart disease over malnutrition. The nationalization of health production ought to control the hidden biases of the clinic.
3. The organization of the medical guild perpetuates ineffienciency and privilege, while the professional licensing of specialists fosters an increasingly narrow and specialized view of disease.
4. The sway of one kind of medicine deprives society of the benefits competing sects might offer. More public support for alpha waves, encounter groups, and chiropractic ought to countervail and complement the scalpel and the poison.
5. The main thrust of present medicine is the individual, in sickness or in health. More resources for the engineering of populations and environments ought to stretch the health dollar.

When people become aware of their dependence on the medical industry, they tend to be trapped in the belief that they are already hopelessly hooked. They fear a life of disease without a doctor as much as they would feel immobilized without a car or a bus. In this state of mind they are ready to be organized for consumer protection and to seek solace from politicians who will check the high-handedness of medical producers.

Nobody knows how much health care will be worth to him in terms of money or pain. In addition, nobody knows if the most advantageous form of health care is obtained from medical producers, from a travel agent, or by renouncing work on the night shift. The family that forgoes a car to move into a Manhattan apartment can foresee how the

substitution of rent for gas will affect their available time; but the person who, upon the diagnosis of cancer, chooses an operation over a binge in the Bahamas does not know what effect his choice will have on his remaining time of grace.

To give an example: it is possible to view health as durable capital stock used to produce an output called "healthy time." Individuals inherit an initial stock, which can be increased by investment in health capitalization through the acquisition of medical care, or through good diet and housing.

Socialist nations assume the financing of all care and leave it to the medical profession to define what is needed, how it must be done, who may do it, what is should cost, and who shall get it.

Attempts to exercise rational political control over the production of medical health care have consistently failed. The reason lies in the nature of the product now called "medicine," a package made up of chemicals, apparatus, buildings, and specialist, and delivered to the client. The purveyor rather than his clients or political boss determines the size of the package. The patient is reduced to an object – his body – being repaired; he is no longer a subject being helped to heal. If he is allowed to participate in the repair process, he acts as the lowest apprentice in a hierarchy of repairmen. Often he is not even trusted to take a pill without the supervision of a nurse.

Unless it disabuses the client of his urge to demand and take more services, consumer protection only reinforces the collision between giver and taker, and can play only a tactical and a transitory role in any political movement aimed at the health-oriented limitation of medicine.

In all of Latin America, except Cuba, only one child in forty from the poorest fifth of the population finishes the five ears of compulsory schooling; a similar proportion of the poor can expect hospital treatment if they become seriously ill.

To be able to afford to give all of the poor equal access to medicine of uniform quality in poor countries, most of the present training and activity of the health professions would have to be discontinued. However, delivery of effective basic health services for the entire population is cheap enough to be bought for everyone, provided no one could get more, regardless of the social, economics, medical, or personal reasons advanced for special treatment. If priority were given to equity in poor countries and service limited to the basics of effective medicine, entire populations would be encouraged to share in the demedicalization of modern health care and to develop the skills and confidence for self-care, thus protecting their countries from social iatrogenic disease.

There are two aspects to health: freedom and rights.

Beyond a certain level of intensity, health care, however equitably distributed, will smother health-as-freedom.

Insofar as medicine is a public utility, however, no reform can be effective unless it gives priority to two sets of limits. The first relates to the volume of institutional treatment any individual can claim: no person is to receive services so extensive that his treatment deprives others of an opportunity for considerably less costly care per capita if, in their judgment (and not just in the opinion of an expert), they make a request of comparable urgency for the same public resources.

The second set of limits relates to the medical enterprise as a whole. Here the idea of health-as-freedom has to restrict the total output of health services within subiatrogenic

limits that maximize the synergy of autonomous and heteronomous modes of health production.

While claims to specialist standing come and go on the fringes, the specialties recognized by the American Medical Association have steadily increased, doubling in the last fifteen years: half the practicing American physicians are specialists in one of sixty categories, and the proportion is expected to increase to 55 percent before 1980. Within each of these fields, a fiefdom has developed, with specialized nurses, technicians, journals, congresses, and sometimes organized groups of patients pressing for more public funds. The cost of coordinating the treatment of the same patient by several specialists grows exponentially with each added competence, as does the risk of mistakes and the probability of damage due to the unexpected combination of different therapies.

By gaining the right to self-evaluation according to special criteria that fir its own view of reality, each new specialty generates for society at large a new impediment to evaluating what its work actually contributes to the health of patients. Organized medicine has practically ceased to be the art of healing the curable, and consoling the hopeless has turned into a grotesque priesthood concerned with salvation and has become a law unto itself. The policies that promise the public some control over the medical endeavor tend to overlook the fact that to achieve their purpose they must control a church, not an industry.

Lay control over an expanding medical technocracy is not unlike the professionalization of the patient: both enhance medical power and increase its *nocebo* effect. As long as the public bows to the professional monopoly in assigning the sick-role, it cannot control hidden health hierarchies that multiply patients. The medical clergy can be controlled only if the law is used to restrict and disestablish its monopoly on deciding what constitutes disease, who is sick, and what ought to be done to him or her.

In the pursuit of applied science the medical profession has largely ceased to strive towards the goals of an association of artisans who use tradition, experience, learning, and intuition, and has come to play a role reserved to ministers of religion, using scientific principles as its theology and technologists as acolytes.

The individual physician in a concrete case may still remember that he owes nature and the patient as much gratitude as the patient owes him if he has been successful in the use of his art. But only a high level of tolerance for cognitive dissonance will allow him to carry on in the divergent roles of healer and scientist.

The religious preference given to scientific language over the language of the layman is one of the major bulwarks of professional privilege. The imposition of this specialized language upon political discourse about medicine easily voids it of effectiveness.

The deprofessionalism of medicine does not imply the proscription of technical language any more than it calls for the exclusion of genuine competence, nor does it oppose public scrutiny and exposure of malpractice. But it does imply a bias against the mystification of the public against the mutual accreditation of self-appointed healers, against the public support of a medical guild and of its institutions, and against the legal discrimination by, and on behalf of, people whom individuals or communities choose and appoint as healers.

It does not mean the abolition of modern medicine. It means that no professional shall have the power to lavish on any one of his patients a package of curative resources larger than that which any other could claim for his own.

The proposal that doctors not be licensed by an in-group does not mean that their services shall not be evaluated, but rather that this evaluation can be done more effectively by informed clients than by their own peers.
Deprofessionalism of medicine means the unmasking of the myth according to which technical progress demands the solution of human problems by the application of scientific principles, the myth of benefit through an increase in the specialization of labor, through multiplication of arcane manipulations, and the myth that increasing dependence of people on the right of access to impersonal institutions is better than trust in one another.
So far I have dealt with four categories of criticism directed at the institutional structure of the medical-industrial complex. A fifth category of criticism rejects these objectives. Without relinquishing the view of medicine as an engineering endeavor, these critics assert that medical strategies fail because they concentrate too much effort on sickness and too little on changing the environment that makes people sick.

8 – The Recovery of Health

Much suffering has been man-made. The history of man is one long catalogue of enslavement and exploitation, usually told in the epics of conquerors or sung in the elegies of their victims. War is at the heart of this tale, war and the pillage, famine, and pestilence that came in its wake. But it was not until modern times that the unwanted physical, social, and psychological side-effects of so-called peaceful enterprises began to compete with war in destructive power.
Man can design his relations to nature and neighbor, and he is able to survive even when his enterprise has partly failed. He is the animal that can endure trials with patience and learn by understanding them.
To remain viable, man must also survive the dreams which so far myth has both shaped and controlled. Now society must develop programs to cope with the irrational desires of its most gifted members.
Prometheus was hero, not Everyman.
He thus inevitably brought nemesis on himself.
The social nature of nemesis has now changed. With the industrialization of desire and the engineering of corresponding ritual responses, hubris has spread. Unbounded material progress has become Everyman's goal. Industrial hubris has destroyed the mythical framework of limits to irrational fantasies, has made technical answers to mad dreams seem rational, and has turned the pursuit of destructive values into a conspiracy between purveyor and client.
A society that values planned teaching above autonomous learning cannot but teach man to keep his engineered place.
No new fuel, technology, or public controls can keep the rising mobilization and acceleration of society from producing rising harriedness, programmed paralysis, and inequality.
Beyond a certain level of industrial hubris, nemesis *must* set in, because progress, like the broom of the sorcerer's apprentice, can no longer be turned off.
The more intense the reliance on techniques making for dependence, the higher the rate of waste, degradation, and pathogenesis which must be countered by yet other techniques

and the larger the work force active in the removal of garbage, in the management of waste, and in the treatment of people made literally redundant by progress.
If this action is to remain human after the framework has been deprived of its sacred character, it needs to be recognized with a new imperative. This imperative can be summed up only as follows: “Act so that the effect of your action is compatible with the permanence of genuine human life.” Very concretely applied, this could mean: “Do not raise radiation levels unless you know that this action will not be visited upon your grandchild.”
But only the awe of the sacred, with its unqualified veto, has so far proved independent of the computations of mundane self-interest and the solace of uncertainty about remote consequences. This could be reinvoked as an imperative that genuine human life deserves respect both now and in the future.
It can be demonstrated that beyond a certain point in the expansion of industrial production in any major field of value, marginal utilities ceases to be equitably distributed and over-all effectiveness begins, simultaneously, to decline. If the industrial mode of production expands beyond a certain stage and continues to impinge on the autonomous mode, increased personal suffering and social dissolution set in.
The recovery of personal autonomy will thus be the result of political action reinforcing an ethical awakening.
... People will limit medical therapies because they want to conserve their opportunity and power to heal.
Better health care will depend, not on some new therapeutic standard, but on the level of willingness and competence to engage in self-care.

The Right to Health
Increasing and irreparable damage accompanies present industrial expansion in all sectors. In medicine this damage appears as iatrogenesis. Iatrogenesis is clinical when pain, sickness, and death result from medical care; it is social when health polices reinforce an industrial organization that generates ill-health; it is cultural and symbolic when medically sponsored behavior and delusions restrict the vital autonomy of people by undermining their competence in growing up, caring for each other, and aging, or when medical intervention cripples personal responses to pain, disability, impairment, anguish, and death.
Medical nemesis is the experience of people who are largely deprived of any autonomous ability to cope with nature, neighbors, and dreams, and who are technically maintained within environmental, social, and symbolic systems.
In several nations the public is now ready for a review of its health-care system. Although there is a serious danger that the forthcoming debate will reinforce the present frustrating medicalization of life, the debate could still become fruitful if attention were focused on medical nemesis, if the recovery of personal responsibility for health care were made the central issue, and if limitations on professional monopolies were made the major goal of the legislation. Instead of limiting the resources of doctors and of the institutions that employ them, such legislation would tax medical technology and professional activity until those means that can be handled by laymen were truly available to anyone wanting access to them. Instead of multiplying the specialists who can grant any one of a variety of sick-roles to people made ill by their work and their life, the new legislation would

guarantee the right of people to drop out and organize for a less destructive way of life in which they have more control of their environment.

Health as a Virtue

Health designates a process of adaptation. It is not the result of instinct, but of an autonomous yet culturally shaped reaction to socially created reality. It designates the ability to adapt to changing environments, to growing up and to aging, to healing when damaged, to suffering, and to the peaceful expectation of death. Health embraces the future as well, and therefore includes anguish and the inner resources to live with it.

A world of optimal and widespread health is obviously a world of minimal and only occasional medical intervention. Healthy people are those who live in healthy homes on a healthy diet in an environment equally fit for birth, growth, work, healing, and dying; they are sustained by a culture that enhances the conscious acceptance of limits to population, of aging, of incomplete recovery and ever-imminent death. Healthy people need minimal bureaucratic interference to mate, give birth, share the human condition, and die.

Man's consciously lived fragility, individuality, and relatedness make the experience of pain, of sickness, and of death an integral part of his life. The ability to cope with this trio autonomously is fundamental to his health.