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Health between the private and the public – shifting approaches

This volume of "Michael" contains the key note lectures and the evening lecture from the international conference "Health between the private and the public – shifting approaches", arranged in Oslo, Norway, September 3rd – 7th, 2003 as a joint venture by the following organisers:

European Association for the History of Medicine and Health (EAHMH)

Det norske medicinske Selskab (The Norwegian Medical Society)

Stiftelsen nasjonalt medisinsk museum, Oslo (The Foundation Norwegian National Medical Museum)[1]

Norsk forening for samfunnshelse (NFSH, Norwegian Society of Public Health)

The International Network for the History of Public Health (INHPH)

Nordisk medisinsk historisk forening

Institute of general practice and community medicine, University of Oslo

Øivind Larsen
conference president

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[1] This volume is also the first in a series of publications from the Foundation.

The international conference on public health history was attended by around 165 participants, coming to Oslo from the entire world. The conference was arranged as part of the 400 years anniversary for the Norwegian public health services. Summaries of the presentations are published in the booklet Kvisvik M, Larsen Ø. (eds.) Health between the private and the public – shifting approaches. *Oslo: The Norwegian Medical Society, 2003. 123 pp. ISBN 82-7703-078-9. During the annversary year, historical seminars, medical exhibitions and other events were held all over the country, in order to strenghthen the ties between the past and the future in public health work. An overview is given in* Michael, *Vol 1, #1, 2004 (in Norwegian), and in the book Pettersen IJ, Siem H. (eds.)* 400 years and the way forward. *Oslo: Ministry of Health, 2003. 160 pp. ISBN 82-7841-210-5. On this photograph, participants at the Oslo conference are listening to the mayor of Oslo, Per Ditlev-Simonsen, during the reception offered by the municipality of Oslo in the Edvard Munch Art Museum on September 3rd, 2003. (Photo Ø. Larsen)*

NFSH
NORSK FORENING FOR SAMFUNNSHELSE
Norwegian Society of Public Health

STIFTELSEN NASJONALT
Medisinsk Museum

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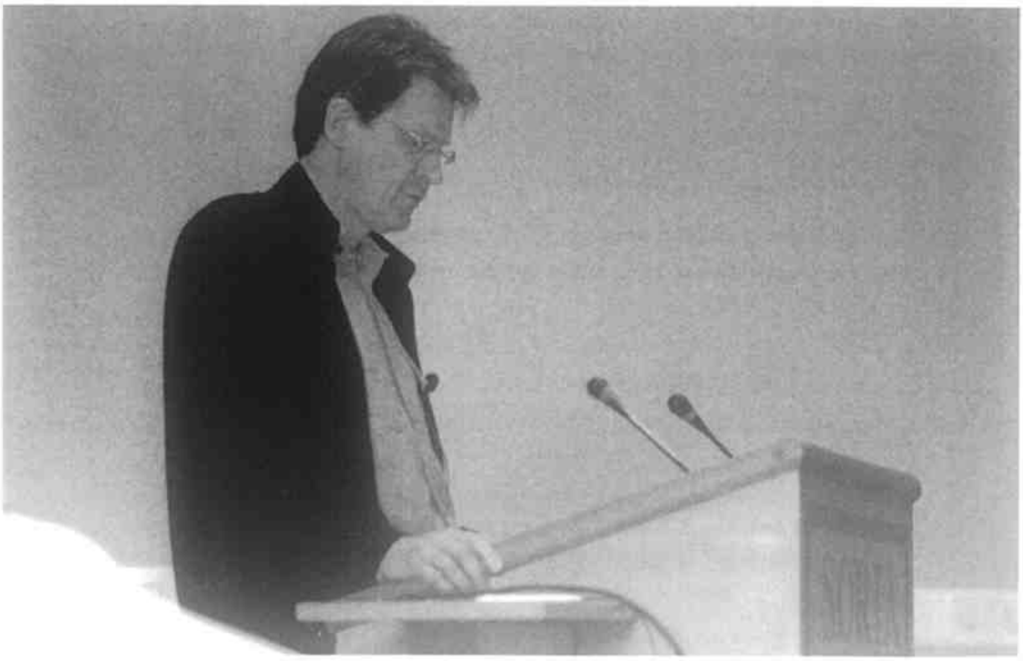
Work begins at the Soria Moria Conference centre on September 4th, 2003 – a glimpse of the audience. (Photo Ø. Larsen)



Keynote speaker, professor Thomas Söderqvist from Copenhagen. (Photo Ø. Larsen)

Thomas Söderqvist

Why are there so few scholarly biographies in the history of medicine and public health?

Michael 2004; 1: 119-129

A meeting like this is a welcome opportunity to raise historiographical questions, i.e., questions about the many assumptions (ontological, epistemological, cultural, or ideological) that guide professional practice in the field of history of medicine and public health.

One such set of historiographical questions has to do with the place and role of the individual in interpretations of the past. Is the individual subject just a social, cultural or linguistic construct? Are "agents" and "actors" primarily defined by webs of discourse? Or do individuals have a role as free and independent creators of society and culture, i.e., as sources of culture rather than its results? And if so, to what extent? Further (to raise the "utility"-question), is the ultimate purpose of interpretations of the records of the past to teach lessons for future collective action? Or is it also to emancipate the individual and to turn him or her into a morally competent global citizen? And finally (to raise the "reflexivity"-question), to what extent do such different opinions about the individual's place in history, express different cultural and ideological assumptions, or even different personal life-experiences, among historians of medicine and public health?

In the wake of such questions and meta-questions about the place of individuals and their experiences in history, there is a whole set of issues concerning the role of biography in relation to other forms of writing about the past. The individual subject and its place in history is one of those historiographical topics we tend to repress, and biography is one of those genres of writing we tend to avoid. Why is this so?

Ten years ago, Ludmilla Jordanova pointed out in an essay review aptly titled "Has the social history of medicine come to age?" that she was struck by "the restricted range of genres and topics tackled" in the history of medicine and public health. She added that "one of the most dramatic examples of this is the almost total absence of scholarly biographies", and continued: "Even for the really big names celebrated by Whig history, few have been the recipients of sustained biographical treatment" (Jordanova, 1993, p. 438). In fact, not even Edward Jenner has received any substantial modern treatment.

I think Jordanova was right in 1993. And even though we have seen some rather impressive examples of scholarly biographical writing since then – consider, for example, works such as Patricia Spain Ward's *Simon Baruch: Rebel in the ranks of medicine* (1994), Jacalyn Duffin's *To see with a better eye: A life of Laennec* (1998) and Michael Bliss's magisterial *William Osler: A life in medicine* (1999) – I am afraid that Jordanova's observation is still valid. The absence of scholarly medical biographies, i.e., biographies about people who have been engaged in medical and public health activities in one way or the other, is indeed dramatic if you compare it with the interest in biographical writing in almost all other fields. General scholarly journals like the *Times Literary Supplement* and the *New York Review of Books* abound with reviews of biographies of all kinds: historical biographies, literary biographies, art biographies, biographies of philosophers, and so on. But rarely medical biographies.

The absence of medical biographies becomes even more dramatic if one takes a look at one of the neighbouring fields: scientific biography. During the last two decades there has been a swell of biographies about naturalists, microbiologists, biochemists, physicists, mathematicians, and geologists; whatever one desires. Books that have made their publishers happy and at the same time have received applause in the scholarly journals. In the last two decades, historians of biology, for example, have produced at least four major Darwin portraits based on meticulous archival research, one even in two volumes (Browne, 1996-2002). Historians of physics have produced several acclaimed studies of Newton and Faraday, and there have been marvellously written treatises of Lord Kelvin, Louis Pasteur, Thomas Henry Huxley, Fritz Haber, Lise Meitner and Rosalind Franklin, just to mention some random fine examples. In my view good biographies not only show how scientists were integrated into the thinking of their time, and how the life and work can shed light on the cultural, political and social context of science, but also investigate the mind and practice of the individual scientist, and even delve into their private lives and existential dilemmas.

Of course, there are many bad biographies as well; some would say too many. But this is what could be expected in global book market that absorbs around one hundred titles of scientific lives every year. Generally speaking, I think there is a general agreement among historians of science today that biography has become a quite respectable scholarly genre over the last two decades. The genre has blown new vitality into our understanding of science past.

If Academia in general and our disciplinary neighbours in particular, have taken biography to their hearts for some twenty years now, why is this not yet the case in the history of medicine and public health? Why are there still so few scholarly medical biographies?

The question becomes even more topical if one contemplates the fact that the medical-biographical genre has a much longer record than most other biographical genres, including scientific biography. Hippokrates, the celebrated, but elusive phantom figure of ancient medicine, had *bioi* written of him already in the Hellenistic period, none of which, unfortunately, is extant. A thousand years later, the miraculous healing powers of some of the medieval saints and their relics found the way into their *vitae*, a genre which later came to be known, somewhat condescendingly, as hagiography (literally saint-writing). And yet another half millennium later, Renaissance and early modern period medical doctors had their given place in the emerging secular biographical tradition, for example in funeral speeches of deceased university professors and in the collections of what was called, obviously by inspiration from Petrarch, "the lives of illustrious men". Medical biography is thus a very old genre, obviously reflecting the fact that medicine and healing is an old practice, whether pursued by hippocratic doctors, medieval saints or professors in the early modern medical faculties and it continues to be published in great numbers (Morton and Moore, 1994).

In spite of being old and venerable, however, the genre has lagged behind its sister genre, scientific biography, for the last three hundred years (the history of the genres of scientific and medical biography remains to be written; see, for example, Söderqvist, 2002a). The first *vitae* of the pioneers of the so called scientific revolution, including Copernicus and Kepler, came in the first part of the seventeenth century. As natural philosophy, astronomy and physics, and later chemistry and the biological sciences, advanced toward the top of the academic pecking order, so did biographical portraits of what gradually became known as scientists, whereas the lives of medical men (and later a few women) were gradually assigned a more humble place in the genre spectrum, compared to the lives of the new revolutionary scientists. Consequently, one of the few medical doctors who repeatedly received biographical notice in the eighteenth and nineteenth centuries was Hermann Boerhaave. Of the approximately 1200 medical-biographical essays and monographs published in the three hundred years between 1550 and 1850, almost all were singletons (Oettinger, 1854); Boerhaave, however, received a top score of seven, the most famous of which was that of his admiring English student William Burton, whose

Account of the life and writings of Hermann Boerhaave (1743) came only a few years after the great master's death. The fact that Boerhaave towers higher than any other in the Enlightenment medical biographical tradition confirms the impression that he was, in the eyes of his successors, the man who brought the scientific revolution into medicine (Cook, 2000).

The triumphs of scientific medicine in the late nineteenth and early twentieth centuries were, of course, reflected in medical lives, too. But they still lagged behind their more illustrious scientific colleagues. Scientists were conspicuously present in the Lives and Letters-tradition; these spectacular and detailed compilations about the great luminaries of the Age of Imperialism, tomes packed with excerpts from letters, often in two, sometimes three volumes. Darwin, Pasteur, Kelvin, Wallace and the other great stars of nineteenth century science all got their tributes. The mathematician William Rowan Hamilton was the subject of 2100 pages in three thick volumes (Graves, 1882-89); the physicist and physiologist Hermann von Helmholtz was memorised by three volumes in German (Koenigsberger, 1902-03). But there were not many great medical doctors among them. And when authors of medical lives eventually adopted this grand format, the era of Lives and Letters had already ebbed out, not least thanks to Lytton Strachey's and André Maurois's attacks on what they regarded as biographical dinosaurs. Harvey Cushing's two-volume *Life of Sir William Osler* in 1925 was one of the most celebrated medical biographies of the interwar period and was indeed a great tribute to the man. In form and outlook, however, it came almost a quarter of a century too late. It was out of fashion before it was even conceived.

I will not try the reader's patience by going into the medical biographical tradition of the rest of the twentieth century, but will hasten to my conclusion of this look-back on the record of the genre, viz., that one reason why there are so few scholarly medical biographies today, compared to, for example, scientific biographies, is that even if medical biography is a very old genre, it never really has had a strong presence as a *scholarly* genre. True enough, tucked away on the shelves here and there are some extremely well-written and thoughtful studies. But, with the risk of sounding contentious, there have indeed been a lot of bad medical biographies. The Biography Room of the Welcome Library in London contains every possible variety of eulogistic, panegyric, hagiographic, badly written, badly organised, badly contextualised biography, in all major languages: English, French, German, Spanish, Italian, Russian, Danish, Swedish, etc. Biographies written by admiring colleagues, devoted students, faithful wives and proud daughters and sons; biographies written out of duty, or as labours of love; biographies that wanted to set the record straight, and so forth, but very few good scholarly biographies.

This lack of a strong scholarly medical biographical tradition may partly explain the absence that struck Ludmilla Jordanova in 1993. But there is also another, and probably more important, reason which has to do with the strong impact that social history has made on the field of history of medicine and health in the last three decades.

If one goes back to the programmatic manifestos of the social historians of medicine in the 1970s and 1980s, one will note the extent to which they were fighting against the biographical genre. They probably did not do so because they were trying to defend a scholarly space of their own against the dominance of scholarly medical biography (because, as we have seen, there was hardly any such tradition), and their fight against biography was probably not driven by a virtuous wish to combat the many bad medical biographies (because there were bad biographies in all possible areas, including lousy art biographies, literary biographies and scientific biographies, now filling dusty shelves in remote library stacks). Neither did the social historians of medicine fight so fiercely against biography because they were influenced by the vague anti-biographical sentiments fuelled by positivism, Marxism, structuralism, new criticism etc., that hovered all over Academia during most of the post-war period (because art historians, literary historians, historians of science etc., continued to produce scholarly biographies apparently without being affected either by the marxist denouncement of individualism, by Roland Barthes's call for the "death of the author", or by the young Michel Foucault's attempt to eradicate the subject (Burke, 1998)).

So why then did historians of medicine in general and social historians of medicine in particular, try to root biography out? Susan Reverby and David Rosner's influential anthology *Health care in America: Essays in social history* from 1979 gives a clue. In their introductory chapter, the editors questioned medical doctors' definitions of health and disease and hegemony over history; they wanted historians to take over professional ownership of the medical past. But there was more at stake. Reverby and Rosner had a much more far-reaching political goal than control of the past: they evidently wanted to have a say about who should control the contemporary medical system. The new social history of medicine was thought to be a weapon that would unmask "the pervasive societal faith in the potential and efficacy of medical science" (Reverby and Rosner, 1979, p. 4). Historians were thought to help break doctors' control over the health system. Reverby and Rosner took the side of patients against powerful doctors, and in doing so; they particularly questioned biographies of "great men", because they believed that biographies were an expression of false consciousness. In their view, medical biographies made the presumed real forces in history – social and economic forces, political discourses, ideologies, patients, nurses, etc. – invisible. In short, biographies upheld the power relations in the medical system.

Confirmed social historians of medicine were not alone in attacking biography as an expression of a deplorable "great doctor"-perspective in history of medicine. With very few exceptions, most professional historians of medicine in the 1980s and 1990s have been hostile, or at best indifferent, to biographical writing (Linker, 2002; Söderqvist, 2002a). This is remarkable, because it was in the same period that Academia in general began to shake the ban on biography imposed by Marxism and structuralism off their shoulders. (Indeed, literary and art historians never found it necessary to fight the art establishment and have therefore apparently not felt any strong need to attack biographies of artists. In fact, it seems as if art historians still feel rather cosy with the idea of the "great artist"; more critical approaches to art biography, like Christie and Orton (1988), have not had much impact).

Likewise historians of science have not felt any strong urge to combat the "great men" of science for political reasons; the idea of "great scientists" has just been considered a trifle unfashionable, so it has rather been a question of moving biography out of the "great man" perspective instead of attacking and denying the genre of biography altogether. As Thomas Hankins wrote in an influential article titled "In defence of biography" published in 1979 (the same year as Reverby and Rosner made their attack), the genre could in fact be used productively to show how the political, social, cognitive, philosophical, etc. aspects of science were working together. Hankins did not see biography as the expression of a suppressive professional ideology, but as a useful methodological tool for exploring science in its wider context.

Hankins's 1979-article announced the come-back of biography as a scholarly genre in the history of science. For the next two decades there has been a surge of scholarly scientific biographies, many of them written with the Hankinsinian purpose in mind. Adrian Desmond's two volumes about Thomas Henry Huxley (1994-97) is a telling example. "This is a story of Class, Power and Propaganda", Desmond announced in the preface: this is "a contribution to the new contextual history of science". And he continued: "Isn't it the modern function of biography to carve a path through brambly contexts? To become a part of history?... And isn't that our ultimate aim, to understand the making of our world?" And again:

"Huxley is part of the new contextual history of science. This itself is a reaction to the old history of ideas, which displaced the person, made him or her a disembodied ghost, a flash of transcendent genius. Only by embedding Huxley can we appreciate his role in the vast transformation that staggered our great-grandfathers" (Desmond, 1997, p. 235).

Desmond and other historians of science have thus given good arguments for not setting social history up against biography and the individual. So it may be time for historians of medicine and public health to begin to reconsider the genre of biography. The omnipotent doctor is not the major culprit any more; today the medical system is in the hands of politicians, health administrators, insurance companies and pharmaceutical multinationals as well. Patients' lobby groups and nursing organisations are beginning to have a say as well. The "great doctor" of the past is largely gone. There is no need to flog dead horses and therefore there is no need to combat biography, because it supposedly obscures power relations, social forces and cultural influences in the medical system.

To use the individual as a lens, as it were, into the larger social and cultural context of philosophy, or science, or art, or literature, or, in this case, medicine and health – i.e., to use biography as a microcosm of history at large, or as an *ancilla historiae* (a servant of history), as I have called it elsewhere (Söderqvist, 2003) – is probably the most common argument among historians today for the use of biography. It is an important role indeed, which, as I have just tried to argue for, makes it more profitable for historians to work *with* biography rather than *against* it. Recent developments in historiographical thinking, such as microhistory and the loose intellectual movement of "new historicism" and its interest in literary tropes, add to the impression that biography and some its salient features, for example the focus on narrativity, are important contributions to medical historiography.

Yet biography is not just history by other means. Even when one speaks of biography as an *ancilla historiae*, one should remember that servants are never entirely in the hands of their masters. Maybe the notion of biography as a adjunct to history should be dropped altogether? As an alternative I suggest to let the ontological assumption which Plutarch made in the introduction to his life of Alexander two millennia ago – viz., that biography (*bios*) and history (*histoira*) are two distinct ways of writing about the past – gloss the present debate about the relation between history and biography.

Remember that *historia* literally means "an inquiry". But in the course of time such inquiries of the past have by tradition come to mean studies of phenomena like nations, classes, economic institutions, political movements, social interactions, cultural constructs, etc.. *Bios* means "an individual life course", and even if some historians today pretend they are writing biographies of cities or countries or even diseases, most historians nevertheless prefer to think about biography as the art of writing the lives of individual human beings. So whereas *historia* by tradition deals with the collective phenomena of the past, *bioi* (*vitae*, biographies) deal with its individuals. One past, two genres.

In other words, even though most historians today think of biography as a genre that takes a secondary role in assisting its more influential master, history, this is not the only role there is for it. Biography has other, more independent, roles as well; for example, at least in the last two centuries is has also been written and read as an aesthetic genre in its own right; literary scholars would probably say that biography has in fact always been emancipated from being a servant to history, that it has always blossomed in its own right.

Medical biography as literature is an interesting topic, which I will not pursue further here. Instead I will use my remaining few minutes to sketch out yet another possible role for medical biography (and in doing so, I will switch from a descriptive-analytical to a somewhat more normative stance). I am thinking of biographical writing as an example of the ancient practice of "spiritual exercises", a tradition which has been high-lighted in Pierre Hadot's (1987, 1995) recent reinterpretation of Hellenistic philosophy (1984) which has also had a seminal influence on Michel Foucalt's idea of "souci de soi" (care of self) in the third and last volume of *Histoire de la sexualité* (1984).

Hadot's point is that already in classical times there was a pronounced difference between "philosophy" in the sense of systems, concepts and theoretical discourses, and "philosophy" as a mode of life. He traces the distinction through the history of philosophy, from Plato, via Petrarch, Montaigne and Descartes, to Kant, Nietzsche and Wittgenstein. One thing is to philosophise about what the world is like, or to find out what justice and goodness may be, or what characterises true knowledge, etc. Another thing is to live and practice justice, goodness, truth, etc.

Hadot uses the term "spiritual exercises" for the kind of practical thinking that informs philosophy in this second sense, as a mode of life (the term itself is not crucial; for some readers it may smack of cheap therapeutical practices, which is not the intention). The point is that there is a tradition in philosophy for "spiritual exercises" as a practice of intensive focus on the intellectual matter at hand, not primarily in order to contribute to the theoretical discourse of philosophy or to understand the world (even if this is a nice side-effect), but to change one's own self in relation to the world.

Hadot restricts his analysis to philosophy. But one can easily extend his distinction to other scholarly activities, in science and medicine as well as in the humanities. Following Hadot, one could then say that it is, of course, a good and admirable thing to do science or medicine to understand the physical world and the human body, or to pursue humanistic scholarship in order to understand language or culture. But it is another, and equally good and venerable thing, to be a scientist or a scholar as a mode of life. Similarly with biography. The purpose of the genre is thus not only to help understand a larger historical context, or to be an aesthetic genre, but also to function as a "spiritual exercise", i.e., to inform the practice of "souci de soi" (care of self), to use Foucault's wording. In other words, biographical writing enhances both the understanding of individual action in the past and the writer's and the readers' understanding of themselves in the world today, thus making them better fit to cope with the present world (cf. Söderqvist, 2002b; Söderqvist, 2003).

Summing up: I believe medical biography has at least two major roles to play in scholarship today. One is to penetrate the intricacies of the medical system of the past by using individuals as lenses, or microcosms, to show how the political, social, economic, military, cultural, and cognitive aspects of medicine and public health have interacted in complex ways. The other is to write and read medical biography as a "spiritual exercise", i.e., as a contemplation of one's place in the contemporary medical and health system and in the world at large. In other words, biographies of scientists, doctors and nurses can help medical and health professionals understand the place of their work in the course of life as a whole; similarly biographical stories of patients may help us all, as potential sufferers, to cope with the situation of being ill. (Maybe even biographies of historians of medicine and public health could be of some use?)

I started by asking: Why are there so few medical biographies? I hope my answer has not scared you from inviting me to the next congress to give the concluding address, but now to answer another question: How can we stem the tide of all these many new and good medical and public health biographies?

References

Bliss, M. (1999). *William Osler: a life in medicine.* Oxford: Oxford University Press.

Bourdieu, P. (1984). *Homo academicus.* Paris: Editions de minuit.

Browne, J. (1995). *Charles Darwin: Voyaging.* London: Jonathan Cape.

Browne, J. (2002). *Charles Darwin: The power of place.* London: Jonathan Cape.

Burke, S. (1998). *The death and return of the author: criticism and subjectivity in Barthes, Foucault and Derrida.* 2nd ed. Edinburgh: Edinburgh University Press.

Burton, W. (1746 [1743]). *An account of the life and writings of Hermann Boerhaave doctor of philosophy and medicine professor of the theory and practice of physics and also of botany and chemistry in the University of Leyden, president of the Chirurgical College in that city, Fellow of the Royal Society in London and of the Royal Academy at Paris.* 2nd. ed., London: Henry Lintot.

Christie, J. R. R. & Orton. F. (1988). *Writing on a text of the life.* Art History, 11, 545-564.

Cook, H. (2000). *Boerhaave and the flight from reason in medicine.* Bulletin of the History of Medicine, 74: 221-40.

Cushing, H. (1925). *The life of Sir William Osler.* Oxford: Clarendon Press.

Desmond, A. (1994). *Huxley: The devil's disciple.* London: Michael Joseph

Desmond, A. (1997). *Huxley: Evolution's high priest.* London: Michael Joseph.

Duffin, J. (1998). *To see with a better eye. A life of R. T. H. Laennec.* Princeton, N. J.: Princeton University Press.

Foucault, M. (1984). *Histoire de la sexualité. 3: Le souci de soi.* Paris: Gallimard.

Graves, R. P. (1882-1889). *Life of Sir William Rowan Hamilton, including selections from his poems, correspondence, and miscellaneous writings.* 3. vols., Dublin: Hodges, Figgis.

Hadot, P. (1987). *Exercices spirituels et philosophie antique.* 2nd. ed., Paris: Etudes augustiniennes.

Hadot, P. (1995). *Philosophy as a way of life: spiritual exercises from Socrates to Foucault,* Oxford: Blackwell.

Hankins, T. L. (1979). *In defence of biography: the use of biography in the history of science.* History of Science, 17: 1-16.

Jordanova, L. (1993). *Has the social history of medicine come of age?* The Historical Journal, 36: 437-49.

Koenigsberger, L. (1902-03). *Hermann von Helmholtz.* 2 vols., Braunschweig: Friedrich Vieweg und Sohn.

Linker, B. O. (2002). *Great doctors, great scientists: the career of biography in the history of medicine and science.* Unpublished paper at the conference "The Poetics of Biography in Science, Technology, and Medicine", Copenhagen, May 22-25, 2002.

Morton, L. T. & Moore, R. J. (1994). *A Bibliography of medical and biomedical biography,* 2nd ed., Aldershot: Scholar Press.

Oettinger, E.-M. (1854). *Bibliographie biographique universelle,* Bruxelles: J. J. Stienon.

Reverby, S. & Rosner, D., eds. (1979). *Health care in America: Essays in social history.* Philadelphia: Temple University Press.

Söderqvist, T. (2002a). *The poetics of biography and the history of science.* Unpublished paper at the conference "The Poetics of Biography in Science, Technology, and Medicine", Copenhagen, May 22-25, 2002.

Söderqvist, T. (2002b). *The life and work of Niels Kaj Jerne as a source of ethical reflection.* Scandinavian Journal of Immunology, 55: 539-545.

Söderqvist, T. (2003). *Wissenschaftsgeschichte à la Plutarch: Biographie über Wissenschaftler als tugendetische Gattung.* In H. E. Bödeker (ed.), Biographie schreiben (pp. 285-325). Göttingen: Wallstein Verlag.

Ward, P. S. (1994). *Simon Baruch: rebel in the ranks of medicine,* 1840-1921. Tuscaloosa: University of Alabama Press.

Keynote plenary lecture: 7th Congress of the European Association for the History of Medicine and Health ("Health between the private and the public: shifting approaches"), Oslo, 3-7 September, 2003.

Thomas Söderqvist
Medical Museion, University of Copenhagen
Bredgade 62, DK-1260 Copenhagen K, Denmark
ph: +45 3532 3815, t.soderqvist@pubhealth.ku.dk

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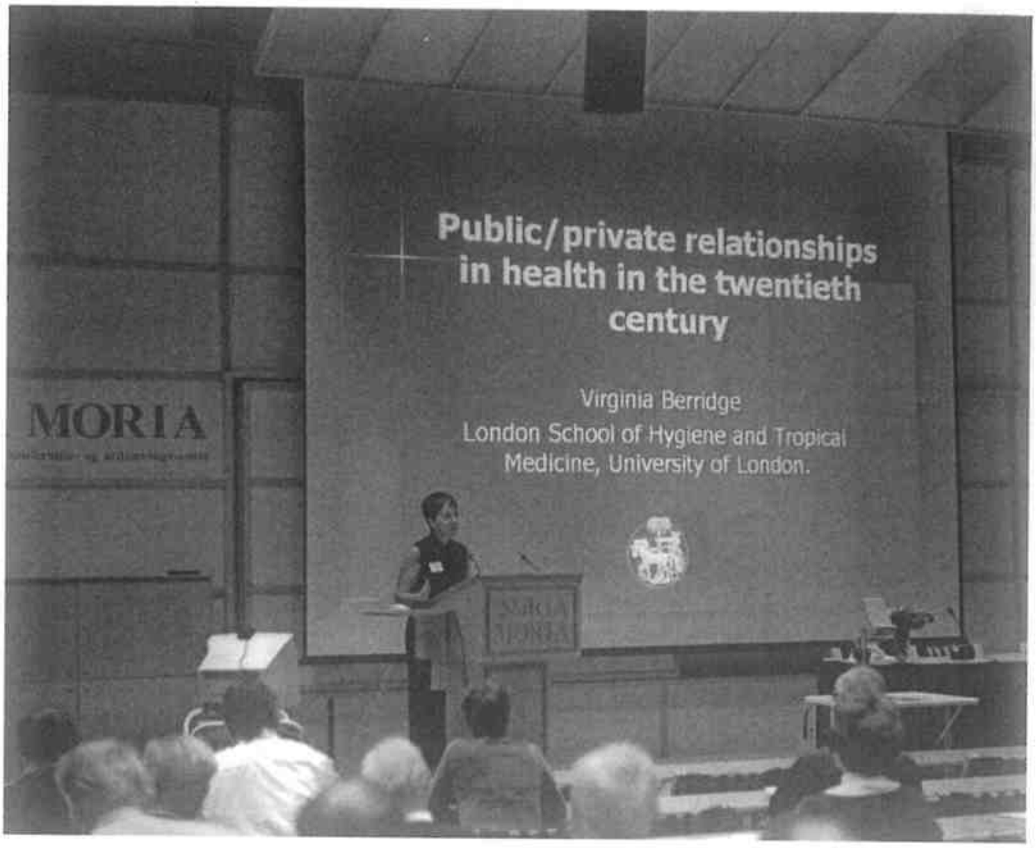


Professor Virginia Berridge (London) giving her keynote lecture. (Photo Ø. Larsen)

Virginia Berridge

Public/private relationships in health in the twentieth century

Michael 2004; 1: 131-144

What do we mean by public and private?

In Britain there have been many recent debates in health policy and in other areas of policy about the issue of public/private relationships and about how partnerships can be formed to the benefit of both sides. The Private Finance Initiative (PFI) in relation to the building and running of hospitals has brought the matter to the fore for health. New hospitals are being built through private finance; the hospitals will be run by the National Health Service (NHS) on a lease, with services provided through private companies. For those who have visited London lately, the new University College Hospital looming over the intersection of Gower Street and Euston Road provides a visual illustration of these relationships. For London Underground Ltd. public/private means a new system where private companies will run the track and signalling, while the state concern provides the services.

This type of interaction between public service provision and private enterprise has been hugely controversial in both areas, but has been a way in which the zeal for complete privatization of public services under the previous Conservative government can be publicly abandoned, while maintaining relationships with the private sector. It became a mantra in some areas of policy, health in particular. My own institution, London School of Hygiene and Tropical Medicine (LSHTM), has recently funded a senior lecturer in public/private partnerships as an initiative in tune with the spirit of the time. These relationships have been visible outside the United Kingdom (UK) as well as in both developed and developing countries. These recent UK debates give a key to one area on which a plenary could focus – this is those relationships in the provision of services.

But the terms also have other meanings, too. Take public health, where the public can mean public space, the wider environment, even the role of the public, the good of the public and how this relates to the role of private family relationships or private individual behaviour.

This brings us to another dimension – the concept of the public sphere. This will be familiar to many in the audience. Hagerman's The *Structural Transformation of the Public Sphere* provided the argument that the intrusion of public authority into private lives through the growth of the welfare services was to erode individual autonomy, turning active citizens into passive consumers of material and cultural goods. As a result genuinely independent and critical forms of public action and opinion, pursued by private individuals voluntarily associating as a public, were compromised, while the power of both private and statutory corporations was enhanced (Hagerman, 1989). Historians have now begun to test this thesis empirically (Sturdy, 2002). There is private and public too, in terms of the role of charity and voluntarism (Mohan and Gorsky, 2001), and the meaning of private as things which are secret and hidden and perhaps revealed to the public.

All these, and more, can be encompassed under my title. Surveying everything would be impossible for such an ambiguous area. What I plan to do therefore is to focus on three themes.

1. Some recent illuminating work on the public/private theme in relation to health services and to public health before 1945.

2. Then to focus on the post-1945 period in relation to the health of the public – a period which seems to be still relatively neglected. How does this reflect some of the issues I have raised?

3. And finally a future research agenda for public and private with and some comment on potential methods and sources.

Public health and health policy up to 1945

For public health, the key change at the turn of the nineteenth and twentieth centuries was from the focus on the public environment, cleansing public space, providing main drainage, water supplies and slum clearance to an emphasis on the role of the family and the modification of individual behaviour through hygiene and health education.

As with all such historical change, the sharpness of the change can be overemphasized. Recent work, for example, Hamlin on Chadwick and public health, has shown how the environmentalism of nineteenth century public health was a surrogate for more general social reform. Its public focus was muted (Hamlin, 1998).

Dorothy Porter has argued that the advent of bacteriology and germ theory, once seen as the motive force behind the 'personalization' of public health concerns in fact served to maintain an interest in the environment, although this time it was the role of the individual in the environment which became the focus (Porter, 1999). Mick Worboy's work on the diffusion of these theories also draws our attention to the unevenness of the spread and to the interaction of environment and individual vector through the idea of 'seed and soil' (Worboys, 2000).

This more recent work on public health serves to modify the sharpness of the public/private change and to make it more. Anne Hardy and others have also drawn attention to its cross-national variation. The hygienic revolution drew its impetus from America and continental Europe in the late nineteenth century, and Britain was slow to adopt some of its principles (Hardy, forthcoming).

For health services, the relationship between public and private in terms of provision and funding has been a strong theme in recent work. In the British context in particular, historians have thrown light on the relationships which prevailed in pre-NHS health services as part of the ongoing revision of the 'moving frontier' of public private relationships in health, with private here also including the role of charitable endeavour.

In some senses, National Health Insurance (NHI) in Britain after 1913 provided the model of an interaction between public health and private provision, but in the form of social insurance it offered something outside both. As Steve Sturdy has recently pointed out, central to the moral justification of NHI, was the fact that the scheme was to be administered through the provident friendly societies and so would bring with it many of the same moral benefits associated with voluntary forms of organized self-help. It was both public and private and something different. The German health insurance scheme which combined state benefits and voluntary organization was seen as a model (Sturdy, 2002).

Here again cross national variation was important in the ways in which these systems operated. Noel Whiteside's comparison of British and French health insurance has compared the pre-war British National Health Insurance system with the post-war French *caisses*. She has shown how in the UK NHI was subject to central control, while, in post-war France, accountability was devolved downwards rather than upwards. Relationships between public and private financing and services were differently organised both nationally and locally (Whiteside, 2002 unpublished).

The relationships between public and private in health service provision did not die out after 1945. Recent work by John Mohan, Martin Gorsky and others, which is being presented at this conference, draws attention to the continuance of mutual health insurance even after the establishment of the NHS. They have drawn attention to the changing nature of the hospital and the public who supported it.

Post-1945 and the health of the public

I will change from survey to special pleading at this point. My focus is the years after 1945, a period, where, as yet, there is less historical work even though its starting point is more than fifty years distant. Most work here has concentrated on the development of health services, but I will concentrate on public health and health policy rather than health services because here there are some interesting interrelationships between concepts of public and private.

The dominant initial theme is the shift from infectious to chronic disease, from potentially public infection to private behaviour as the focus of public health post-1945.The emergence of the chronic diseases – cancer, diabetes, heart disease – as matters of main concern for health was consolidated post-World War Two, and these became seen as matters of private, of individual responsibility. The public became private.

The case of air pollution and/or smoking

Let me focus down on a period in Britain in the late 1950s and early 1960s, where we can see this change being negotiated. The discussions around the relative responsibility of smoking or of air pollution for lung cancer in the British context give us a sense of the rationales behind these developments. Whether air pollution or smoking was the prime cause of lung cancer in a sense epitomised the public/private tension within public health at this stage. Here I mean public in the sense of environmental and private in the sense of behavioural and individual. We can see a change of emphasis – away from air pollution – very clearly in the discussions which took place in the committee appointed by the Royal College of Physicians in 1959 to consider the smoking and air pollution issue.

The committee was set up as one on smoking and air pollution. It was to consider both, the connection between them, and to produce a report.

But the committee decided not to do this, and its reasons were interesting. At its meeting on 17 March 1960, it decided that it would publish a separate report. Smoking had to be given priority.

> It was agreed that the evidence would be of an entirely different quality and nature. It was pointed out that individuals could avoid the dangers of smoking but not those of pollution. It was also thought that a section on atmospheric pollution within the main report might detract from the main arguments on smoking and lung cancer (Royal College of Physicians, 1960).

There were also political reasons for this focus. The British government was alarmed, not at the smoking issue so much as at the political implications of too much stress on air pollution. In the late 1950s when the MRC proposed to include in a statement that up to 30 per cent of lung cancer might be caused by air pollution, there was political alarm. This would give air pollution, the minutes of the Cabinet committee record, 'unwarranted prominence'. The committee thought that Professor Bradford Hill and Dr. Doll had failed to show any substantial difference in risk among non-smokers in greater London and in rural areas. So the politicians asked the MRC to re-examine their statement. Both statements, so it was commented, had obvious political implications. The statement was subsequently modified. The MRC had re-examined their draft and proposed to modify the references to atmospheric pollution which implied that it might be responsible for up to 30 per cent of such deaths. The section would read instead,

> ...On balance it seems likely that atmospheric pollution plays some part in causing the disease, but a relatively minor one in comparison with cigarette smoking.

A further section was modified to read: 'A proportion of cases, the exact content of which cannot yet be defined, may be due to atmospheric pollution.'

The pollution issue was effectively headed off. Cigarette smoking was preferable as a public health issue. Financial responsibility could be, at this stage, contained at the local government level; the scientific evidence pointed in that direction; and the action to be taken was really up to the individual. Air pollution was the issue with wider public implications which had to be damped down politically (Cabinet Office 1957).

What we are seeing here at the end of the 1950s and the early years of the 1960s is the rise to significance of a new style of issue which emphasised individual responsibility rather than environment, occupation, class or work. One can see that as 'science driven'. The epidemiological research on smoking and lung cancer was ultimately decisive, and that certainly played its part in this transition. Also in play, as I have indicated here, were direct political factors, which caused the modification of the MRC's statement, but also wider issues of changes in the whole outlook and location of public health?

Here was a new public health struggling to be borne, no longer an environmental issue rather a question of remedying the defects in individual lifestyle. The rise of this style of thinking can be traced both nationally and internationally through, for example, the 1974 Lalonde Report and through documents like Britain's *Prevention and health: Everybody's business. A reassessment of public and personal health* (1976).

Private is also public

But the emphasis on private behaviour was always located paradoxically within frameworks which can be termed public, and it is these interactions and their change over time which I want to spend some time exploring. There is a paradox here that private and public were reconfigured and interrelated in the new public health, but in ways in which we can also tease out different definitions of public and private.

Take, for instance, the notion of public in public health science. The scientific discipline at the heart of the transition in the public health focus, risk factor epidemiology, stressed individual behaviour modification and individual responsibility for health. Yet the concepts of epidemiology married concern for a population base – for overall public change – with whatever benefits accrued to the individual. The individual was only important, as the British epidemiologist Geoffrey Rose wrote, as part of the population as a whole. This was the prevention paradox. Population change was necessary, although the benefits to the individual might be more intangible (Rose, 1992). Risk was a concept which was both private and individual and public at the same time.

Individual behavioural concerns concentrated on smoking, on diet and on the role of heart disease. But it was perhaps AIDS in the 1980s which highlighted this tension between private behaviour and its impact on the population. AIDS was an epidemiological syndrome par excellence; and it also exemplified key tenets of the new public health, stressing individual behaviour modification, individual responsibility, but also the rights of the individual, all within a context which had the interests of the population, the public at large, as a primary political and health concern (Berridge, 1996).

Publicity and private behaviour

Mention of AIDS – and of the other public health topics – brings us to another dimension of the continuing public/private interface in post-war public health. This is the key role of publicity and the media in the post-war concern for the modification and regulation of private behaviour. Drinking, smoking, eating, drug taking, sexual activity – private behaviour – became public property through what David Miller and Jenny Kitzinger in their study of AIDS and the media, have called a 'circuit of mass communication', a network of interests ranging through politics, health, media production and dissemination processes (Miller and Kitzinger, 1998).

This was a process which also has a history and one which is beginning to be traced. In the post war period media matters took on a wholly new dimension. As Kelly Loughlin has shown in a forthcoming paper, notions of privacy and confidentiality, of the private nature of the doctor/patient relationship were affected by the coming of the NHS. She uses the media furore in the 1950s surrounding the birth of conjoined twins to demonstrate how the dual influences of the growing media interest in health and the establishment of a state funded health system brought in their train an extended and altered notion of confidentiality (Loughlin, forthcoming). This was the media interest in health which was also symbolized by Charles Fletcher's path-breaking programme about surgery, *Your Life in Their Hands*, in 1958.

These developments were accompanied by the establishment of a sophisticated press and public relations machinery within medicine's professional base. For example, the British Medical Association's (BMA) policy towards the media began to shift in the late 1950s. Active and targeted engagement with the media by BMA spokespeople was seen as a way in which to reinforce its public perception, pressing the associations' contribution to medical science rather than the self-interested issues of pay and conditions. In doing this, the representatives of medicine were interacting with a new type of specialist in the media – the health services correspondent. Medico-politics and the NHS was an area pioneered by John Prince, a former lobby correspondent at the *Times* who moved to take up the position of health services correspondent at the *Daily Telegraph* in 1957.

Medicine in general was becoming more public. But these developments were particularly noticeable in the area of public health, where the emphasis overall was on the modification of private behaviour. Public education, of course, had long been part of the public health and hygiene remit. But this transmuted into a new mass remit from the 1960s. Let us look at a committee which epitomized the change, the Cohen committee of 1964. Here we can see a style of health education and public health in development which was very different both from pre-war health education with its group discussions, 'filmlet shows' or home visits. The committee itself was permeated by a strong media focus. Its deputy chair came from the Consumers Association (and previously the BBC), while, along with the traditional medical contingent, were an advertising agency representative and the health editor of *Woman* magazine. The traditional health education focus had been on individual advice to mothers and advice on specific action like vaccination and immunization. But the committee considered that more education was needed on human relationships – sex education, mental health, the risks of smoking and being overweight, and the need for physical exercise. These were difficult areas, the report commented, where self-discipline was required.

There was a strong emphasis on the role of individual risk avoidance, mingling moral and medical imperatives. The report placed emphasis on a greater degree of central publicity, using habit changing campaigns and social surveys, as well as strengthening the new profession of health educators. This new breed was to be trained, on the American model, in journalism, publicity, the behavioural sciences and teaching methods. Training people would involve both imparting knowledge and inculcating self-discipline – a telling phrase. The brief of health education was changed from the earlier information dissemination model just a few years earlier. Telling people and giving information about health also involved, it stated, persuading people to take appropriate action. Knowing about the risks of cigarette smoking was no good unless accompanied by an appeal for appropriate and urgent action.

The report emphasised the role of the mass media in health education. One TV programme, it commented, could reach 5 million people, whereas it would take 250,000 group discussions of 20 each to target the same audience. There should be a central body to take forward these changes and to evaluate them. It would be staffed by new health educators, trained in psychological skills, decision-making by group skills. The Report ultimately led to the setting up of the Health Education Council (HEC) in 1968, reconstituted in the early 1970s (Cohen Report, 1964).

The committee's report was the portent of a new style for public health. Post war public health and health education took the central role of the media in society as its animating idea in modifying private behaviour. The campaign mounted by the advertising agency Saatchi and Saatchi for the newly established HEC in the early 1970s demonstrated the new ethos, derived from changes which had their origin in the US advertising scene.

Advertisements in 1971 showed smokers crossing Waterloo Bridge intercut with film of lemmings throwing themselves off a cliff. A voice over said:

> There's a strange Arctic rodent called a lemming which every year throws itself off a cliff. It's as though it wanted to die. Every year in Britain thousands of men and women smoke cigarettes. It's as though they want to die...

Women re-emerged in the 1970s as a major focus of new style health education for smoking. The most striking image from a campaign run in 1973/4 was a naked mother smoking. 'Is it fair to force your baby to smoke cigarettes?' it asked. There was a clothed version of the pregnant smoking woman, but evaluation concluded that it was less effective as a campaign tool. The commercialization of the private was seen as necessary for the modification of public behaviour (Berridge, forthcoming a).

Health activism and science: public and private

Use of the media in this way – through behaviour altering campaigns – has remained central to public health, as much with AIDS in the 1980s and 1990s, as smoking or diet in the 1970s. A distinctive style of health activism emerged which used the media rather than mass membership as its negotiating tool. ASH (Action on Smoking and Health), founded in 1971, was a prime example. Media 'stunts' and 'spin' were pioneered in the 1970s for health. The basis of such groups epitomized the public/private interface; ostensibly private associations of concerned citizens, they were in fact almost entirely state funded (Berridge, forthcoming b).

The centrality of the role of the media for public health was underlined by the way in which restriction of opposing media became the central policy strategy. Public health activists saw mass media as the central terrain to be used and to be fought over. Restriction and ultimately prohibition of tobacco advertising became central to the public health case from the 1970s.

Increasingly, the scientific advice on which behaviour change was to be based came to be a media event. Stephen Hilgartner's recent *Science on Stage* sees the emergence of three reports on nutrition and health in the US in the 1980s as an example of the stage management of expert authority. He draws out the contrast between a 'backstage' of production (negotiation and dispute among committee members) and a deliberately staged 'front stage' of unequivocal consensus (Hilgartner, 2000). The role of journalists and public relations specialists in this process should also be acknowledged and the changing nature of the interactions. When the Royal College of Physicians (RCP) launched its first report on Smoking and Health in 1962, it deliberately aimed the report at public and policy makers. A public relations specialist was hired, and the College held a press conference for its launch – then an unheard of event. (Berridge, 1998). Increasingly the public health fact is a media event.

Private industry and public health

One issue which this media focus underlined was the role of another sort of private – the role of private industry and public health. Here the media publicity agenda has been one determinant of a strongly anti-industry line. As Mike Daubed, an early Director of ASH, told me in an interview, he used the US activist text, *Rules for Radicals* where it said 'personalise the problem' – 'the people running the major companies are responsible for those deaths'. Increasingly, hostility to private industry became the public face of public health activism – notably for smoking, but also in relation to diet and the role of food interests and for alcohol as well. This became allied to an absolutist agenda from the 1970s which aimed at the elimination of harmful individual behaviours rather than their modification.

Yet there is another side to the relationship between public health and private industry which has been less explored. In the British context, there was the continuing cooperation 'behind the scenes' between industry and some public health interests during the 1970s and 1980s. Although this cooperation was centred around the issue of 'safer smoking' and the development of tobacco substitutes, later through work on the role of nicotine and what role nicotine could play in the reduction of smoking related harm. It is not helpful historically to see such interactions only through the US inspired 'heroes and villains' framework inspired by the revelations of industry documents.

There are also other ways in which the role of private industry in public health is beginning to be explored. Vivienne Quirke, for example, in a forthcoming paper, has looked at the role of pharmaceutical industry interests in the development of drugs for chronic disease. She has shown how developments in private industry – pharmaceutical innovation – also underpinned the rise of lifestyle public health (Quirke, forthcoming). The industrial dimension to public health change needs further exploration; the 'invisible industrialist', recently much discussed in science and technology studies, should make an appearance here too.

1980s and 1990s:
public health draws on private and public

I drew attention at the beginning of this paper to the focus on individual and private behaviour implicit in the new post-war public health. In the 1980s and 1990s that has begun to change. The environment and the role of the public have made reappearances, although in ways which stress the interaction of public and private which has been a theme of this paper.

For smoking the concept of passive smoking essentially combined the individualism of 1970s public health with the environmentalism of the new public health. No longer was this simply a matter of private risk; now it was a matter of risk to the community as a whole, an argument similar to those advanced at about the same time in relation to HIV/AIDS. The 'innocent victim' was a powerful component of the new relationships between private and public.

This was the private individual in public or workplace space. Environmentalism at the level of the city or locality can mean control of the individual, for example, through the concept of 'community safety' and its recent elaboration in drug and alcohol-free spaces.

Research agendas and methods

Mention of drugs and alcohol brings me near a concluding section which will focus more on what needs to be done with some comments on research methods. I started this paper with an outline of the differing meanings of public and private which could be drawn on. Some of these I have touched on in the paper, but there is obviously room for much more. Let me just outline a few ideas.

1. Specific diseases or policy areas is one way into this arena – and many of the papers in the conference take this approach. Drugs and alcohol provide some good example of interrelationships. Sarah Mars will be talking about public and private in relation to addiction treatment later on. Alcohol policy also provides a good example of how different national cultures and regulatory regimes can combine public and private in different ways.

2. Cross national comparisons are an important part of examining the interaction between public and private. The state alcohol control regimes in some Scandinavian countries have distinctive histories and

are being or have been dismantled under the impact of EU requirements.

3. Global and European dimensions. For a post-1945 historian, the European Union (EU) and its role in health is an important part of the public/private interface. So, too, are the global health agencies which so far have been little mentioned. The recent enthusiasm in WHO for global public/private partnerships is a historically contingent phenomenon which should be studied. There is now a whole host of international agencies which have been promoting the role of the private sector in public health for some while. The World Bank and the World Trade Organisation have been major players in globalisation of health regimes – for example, the requirement for policies of structural adjustment in developing countries. The health economists at LSHTM who specialise in developing countries have long had public/private as an arena of research.

So there is plenty to be done and much material available. Among that material is, of course, the testimony/evidence of those who are 'living actors' in events. I am still surprised how little such material is used. Working in an environment such as the London School, I am surrounded by historical actors, although ethical restrictions may make such interviews and access more difficult in years to come. The public testimony, individual 'witnesses' may perforce become private.

There is no lack, too, of archival material. Our Centre at LSHTM has been well served recently by the UK health department which has given several of us access to very recent material – a development which other historians, who assume they have to stop archival work in the 1970s, seem not yet to have noticed. Such material is complemented by the internet offerings which are becoming ever more frequent. The recent Hutton inquiry documentation into the death of the Iraq scientist David Kelly placed on the internet is part of a trend which has seen the British government's BSE papers and other enquiries also made available. Like the industry archives also revealed in recent years, these sources need to be treated with caution. More than most archival material we know little about what has been produced and what has not and the contextual background. Nevertheless, this is part of a trend by which the historian's 'private' material is potentially available to a wider public, an as yet undeveloped part of the enthusiasm for 'public history'.

So there is plenty more which could be said about post-1945 public health and about the interactions between public and private which have characterised it. Historical work in this area is vital, for it can uncover the changing meanings of these terms and the close interactions between private and public which have characterized the changing nature of public health and health policy.

References

Berridge, V. (1996) *AIDS in the UK: the making of policy, 1981–1994.* Oxford University Press, Oxford.

Berridge, V. (1998) Science and policy: the case of post war British smoking policy. In Lock, S., Reynolds, L., and Tansey, E. M. eds. *Ashes to Ashes: the history of smoking and health.* Rodolpi, Amsterdam. 143 -163.

Berridge, V. (forthcoming 1). *Smoking and the new health education in the UK, 1950s-1970s.*

Berridge, V. (forthcoming, 2).Government funded voluntary sector or new social movement? The case of ASH (Action on Smoking and Health) in the 1970s. In Pelling, M. and Mandelbrote, S. *Essays in honour of Charles Webster.*

Cabinet Office, 1957. *First meeting of Cabinet committee on cancer of the lung. 7 May 1957.* Memorandum on MRC Report. 31 May 1957. Appendix A.Draft statement. CAB130/127/GEN 58.

Cohen Report (1964). Ministry of Health. *Health Education. Report of a Joint Committee of the central and Scottish Health Services Councils.* HMSO, London.

Habermas, J. *The Structural Transformation of the Public Sphere: An Inquiry into a Category of Bourgeois Society.* Polity Press, Cambridge.

Hamlin, C. (1998). *Public Health and Social Justice in the Age of Chadwick. Britain 1800-1854.* Cambridge University Press, Cambridge.

Hardy. A. *Public private relationships in health* (forthcoming in proceedings of Bergen conference)

Hilgartner, S. (2000). *Science on Stage. Expert Advice as Public Drama.* Stanford University Press, Stanford, Ca.

Loughlin, K. (forthcoming) *Spectacle and Secrecy; press coverage of conjoined twins in 1950s Britain.*

Miller, D., Kitzinger, J., Williams, K., Be Harrell, P. (1998). *The Circuit of Mass Communication. Media Strategies, Representation and Audience reception in the AIDS Crisis.* Sage, London.

Mohan, J and Gorsky, M. (2001) *Don't Look Back? Voluntary and Charitable Finance of Hospitals in Britain.* Past and Present Office of Health Economics, London.

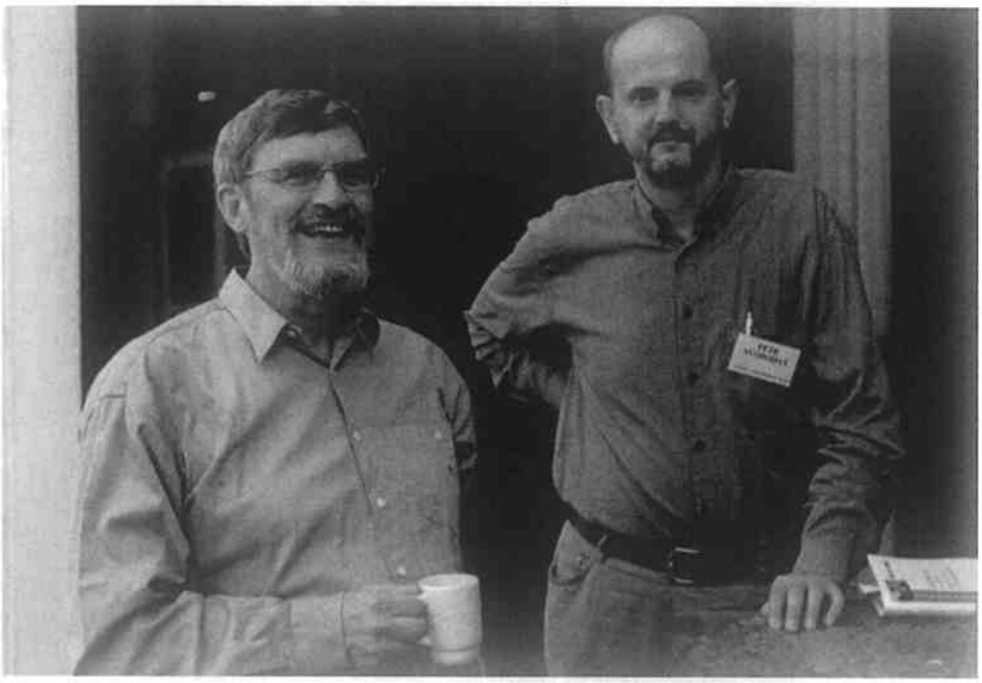
Porter, D. (1999). *Health Civilization and the State. A history of public health from ancient to modern times.* Routledge, London.

Quirke. (Forthcoming) From Evidence to Market: Alfred Spanks' 1953 survey of new fields for pharmacological research, and the origins of ICI's cardiovascular programme. In Berridge, V., Loughlin, K. (eds.) *Medicine, the Mass Market and the Media.* Routledge, London.

Rose, G. (1992). *The Strategy of Preventive Medicine.* Oxford University press, Oxford. Royal College of Physicians, (1960). Committee to report on smoking and atmospheric pollution. Minutes of fourth meeting.17 March 1960. Royal College of Physicians archive, London.

Sturdy S. (2002) *Medicine, Health and the Public Sphere in Britain, 1600-2000.* Routledge, London.
Sturdy, S. (2002). Alternative publics. The development of government policy on personal health care 1905-1911, In Sturdy, S. (2002)241-259.
Whiteside, N. (2002) seminar paper given at LSHTM history seminar.
Worboys, M. (2000) *Spreading Germs. Disease Theories and Medical practice in Britain,* 1865–1900. Cambridge University Press, Cambridge.

Virginia Berridge
London School of Hygiene and Tropical Medicine
Keppel Street
London WC1E 7HT, UK



Keynote speeker Jan Sundin (Linköping) and Petr Svobodny (Prague). (Photo: Ø. Larsen)

Jan Sundin

Health and social change – a comparative perspective

Michael 2004; 1: 145-162

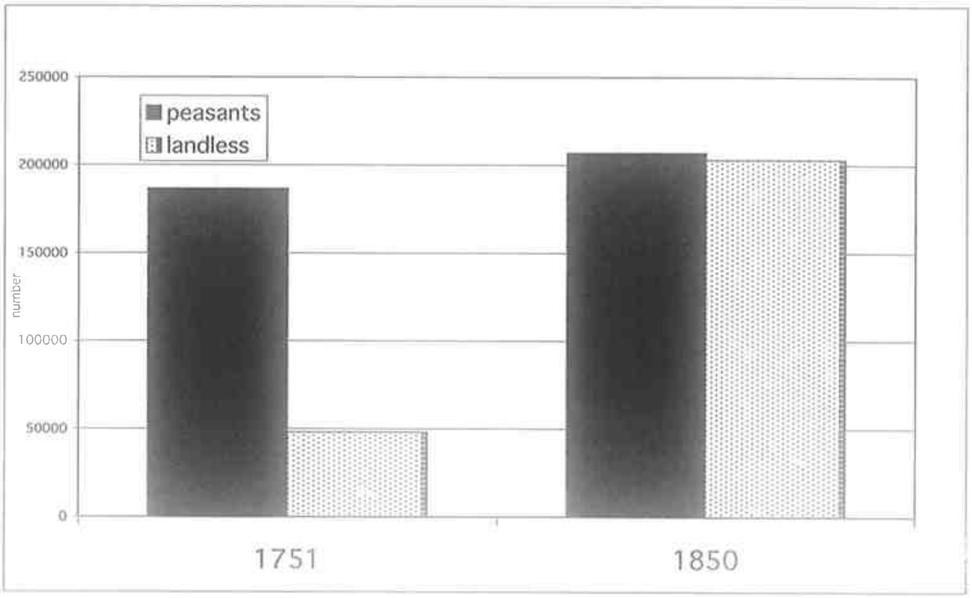
Neither 'health' nor 'social change' is an easy concept to define in a precise way. For most contemporary scholars, health is not the opposite of disease, even if disease is the most obvious threat to health. One can very well imagine a person having relatively good health in spite of being ill. Conversely, a person may lack important elements constituting good health, without being medically diagnosed with a disease. Let me – in this context – suggest a definition of health, which is a bit wider than the *"biomedical"* model. In *WHO's* famous words, 'health' is related to 'well being' – 'complete health' meaning 'complete well being'. In the context of social change, I would prefer a more limited range, where *health is one's physical and mental capacity to realise reasonable vital goals of life.* Otherwise, temporary feelings of sadness (for instance among Swedes who are not able to beat South African high jumpers in the world championship) would be signs of bad health. Nor may inherited physical and mental handicaps necessarily be defined as bad health *per se*. It depends on how much the handicap threatens the vital goals in a given context.

Health will – by this definition – also depend on the cultural, economic, social and political circumstances in which one is living. The culturally changing definitions of health will depend on what is considered to be reasonable goals of life. A lack of socio-economic resources is not a lack of health itself, but it will often be an obstacle to good health (good physical and mental resources given one's genetic heritage) and therefore prevent one from fulfilling the vital goals of life. The possibilities to realise these vital goals will depend on the socio-economic resources of society and of oneself within this structure, including the politically shaped resources or obstacles for good health.

This leads to an image of health and society (either on the structural level or for a certain individual) as a mutual relationship between different types of resources, which are together identical with a great part of what we call 'welfare'. Health is both a resource for the creation of other resources and dependent on these resources – both the health of one person and "the people's health". Everything from genetics to culture influences health. What needs to be discussed in this context is its relation to the social fabric and the way it changes.

We are, given these starting points, forced to reduce the complexity and multitude of factors when trying to uncover the network of factors and interdependencies. We must be aware of the difference – and interplay – between the effects of social change on single individuals versus the effects on the whole society or groups within the society. Some of these effects can be measure by quantities, percentages, as chances or risks characterizing populations. Other effects have to be analysed in a qualitative way, comparing one system with another. Given that health depends on a number of socio-economic resources, allow me to present some relatively simple statements with graphics from 19th century Sweden as examples of my own understanding of health and social change.

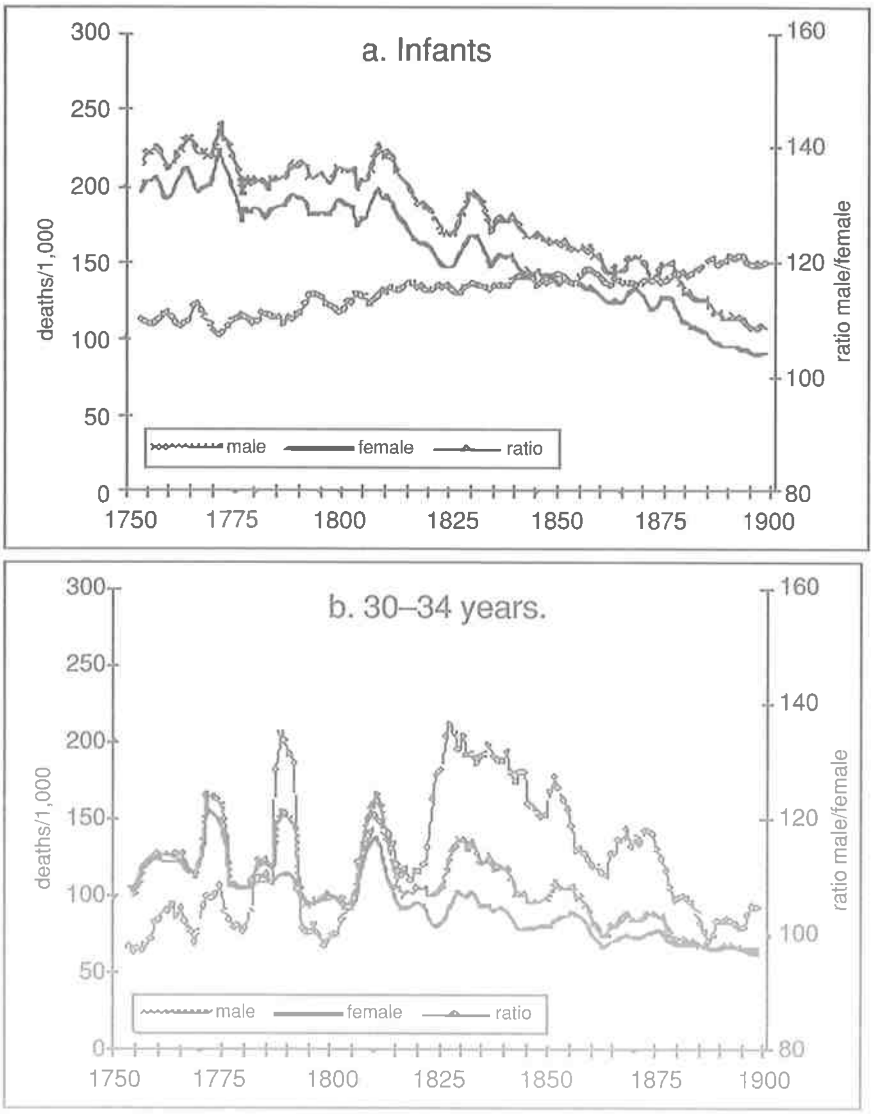
Fig 1. *Number of heads of household in the Swedish countryside among farmers and landless persons.* Source: *Sundin and Willner 2003, p 31.*



- *Changes in the labour market, social structure and social security systems put a heavy burden on people's occupational flexibility, social adaptability, and ability to find economic safety for themselves and their families.*

Theoretically and as far as data allow us to prove it, basic material conditions are closely linked to health. To get a decently paid work and social

Figure 2. *Infant mortality (a) and mortality 30–34 years (b) in Sweden 1750–1900.* Source: *Sundin and Willner 2003, p. 36f.*



security are two essential elements for safety and health. Changes force people to find new ways in order to acquire those resources, a challenge for those affected. *Figure 1* illustrates the transition of Sweden from a predominantly agrarian society with a majority of households of farmers, their kin and servants in mid-eighteenth century. One century later, the landless population, relying on casual employment and with limited social security, had grown drastically and constituted almost 50 % of all households. The reason for its growth was twofold: population growth caused by declining mortality parallel to the rationalisation of agriculture, creating a surplus of people looking for work. The result was circular migration of young men and women in rural areas and into the still small and pre-industrial cities, often surviving on a day-to-day basis.

- *Transitions that are fundamental and rapid often have immediate, profound effects on health.*

Social change takes place all the time and everywhere. Some changes are less dramatic, some are relatively slow, giving individuals and collectives the possibility to adapt and find new ways to realise the good life. Not surprisingly, profound and rapid changes have – as empirical evidence suggests – visible effects on health as well. Not all changes are of course negative for health. People in growing economies tend to become healthier. Some changes have been positive in the long run, while they have had negative effects for parts of the population during the initial phases.

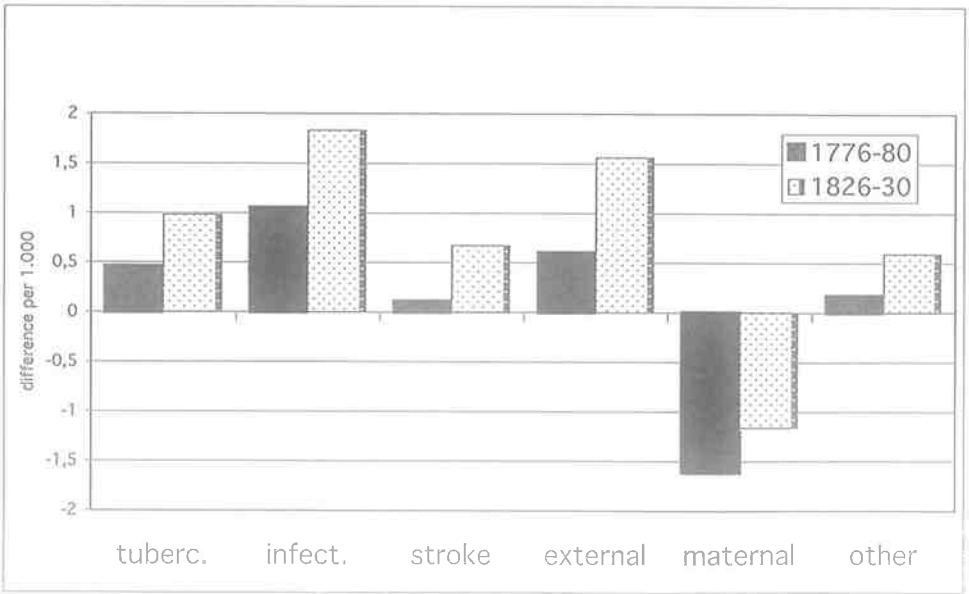
What, then, did the social and economic transition mean to the people's health in early nineteenth-century Sweden? As a matter of fact, the crude mortality rate declined steadily after 1810, indicating a substantial improvement of their health in spite of economic and social restraints. However, dividing the figures by age and sex in *Figure 2* reveals a more complex situation. Infant, child and adult female mortality went down simultaneously, while adult men did not prosper from the same positive development.

- *Welfare and health also depend on gender, age, and social class.*

Generally, enough evidence has been produced to show that gender differences of health or mortality are not exclusively – or even mainly – depending on genetic factors. In many societies where there is a certain degree of equity between the sexes, adult males tend to suffer more than women, especially from lethal health problems. A large part of this surplus mortality is caused by male behaviour – excessive drinking, heavy smoking, drug abuse, violence or other types of risk behaviour. Gender – culturally constructed roles – is in several ways the mediating factor between society and sex specific mortality. Since gender roles are linked to age and class, all three factors contribute to case specific health patterns. Being a relatively poor, unmarried, middle aged man in an urban influx area during periods of rapid social change does, for instance, seem to fit badly with the male gender role, increasing health risks.

So, if we are looking for a group that was particularly vulnerable to the changes taking place during this period of time in Sweden that is where we should find it. And data confirms our expectations. Men were not in general in an economically worse situation – probably on the contrary. They usually earned more than women, and yet the expected differentials caused by class and civil status were greater among men than among women, particularly in the urban areas.

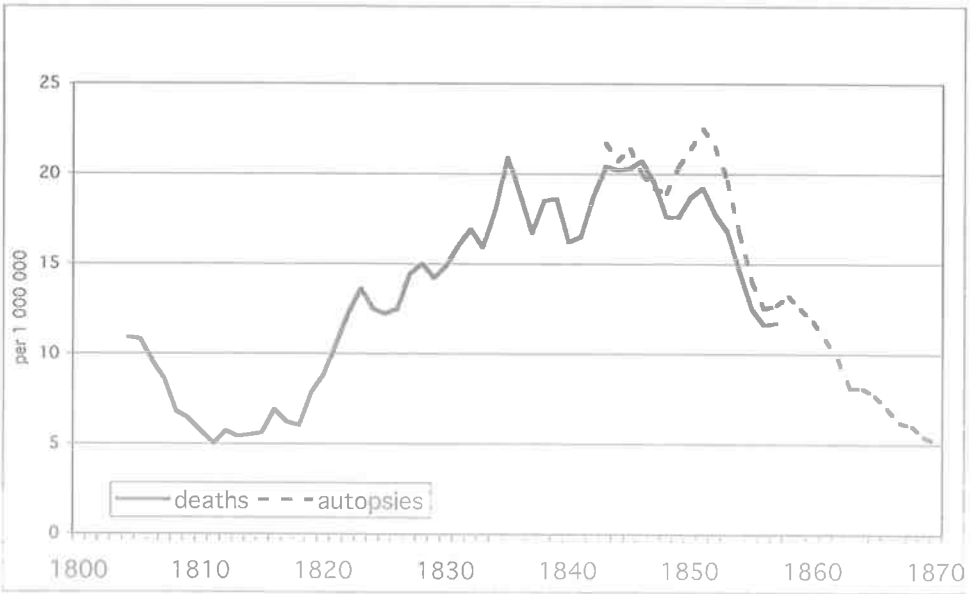
Figure 3. *Sex differential causes of death, 25-49 years of age, in Sweden 1776-80 and 1826-30. 0 = no difference; 1 = 100 % difference, etc. Male surplus above 0-line, female surplus below 0-line.* Source: *Sundin and Willner 2003, p. 40.*



- *Cultural and gender factors within a particular epidemiological setting often have different effects on the health of men and women.*

Although there seems to be a certain tendency for men to run the highest risks, cultural patters – for instance in highly traditional patriarchal societies – may change mortality patterns, making women more vulnerable. HIV/AIDS shows that this can be particularly dangerous in a certain epidemiological milieu. However, in the Swedish case 200 years ago, the result is in line with the more general pattern. Cause-specific mortality based on the categories reported in contemporary death statistics, is not always easy to interpret. The story told in *Figure 3* is, however, consistent enough. Male surplus mortality and its increase existed in all groups except maternal deaths both in the 1770's and 50 years later. The very high male figures for "external causes" (accidents, assaults, suicide, etc.) is particularly striking and congruent to similar patterns in today's examples of rapid social change. The figures indicate that a common factor influenced most types of mortal diseases and – at the same time – hazardous male lifestyles.

Figure 4. *Deaths caused by acute alcohol intoxication in Sweden 1804-1870 according to death registers and autopsies.* Source: *Sundin and Willner 2003, p. 43.*



- *If social and geographical mobility increases, some people benefit while others lose out.*

- *During rapid changes, old norms, rules and institutions no longer function as efficiently as they did before.*

New economical structures mean that old jobs disappear and – at the best – new jobs are offered elsewhere with new skill requirements. Geographical and social mobility tend to increase, a chance of improvement for some but a risk of failure for others. The more dramatic these changes are, the higher the risk of failures. While the 'winners' may benefit materially and feel safe and satisfied, the 'losers' may suffer. In the end, the latter affects health negatively in a diversified way: from economically and psychologically induced problems to behaviour that is directly or indirectly negative for the health of oneself or others: starvation, alcoholism, smoking, externally caused health problems, etc.

The way to individual safety is regulated by customary norms and rules: what kind of skill to acquire, how to behave, where to go for help, etc. Formal and informal institutions exist in order to regulate this process and traditional ways are often not fit for new socio-economic circumstances. In addition, a new social context usually means that even norms that are not directly related to the material sector are changing, increasing the risk of confusion and 'anomy' in Durkheim's sense of the word – a psychosocial process.

A large part of the generation of men born in farmers' households in nineteenth century Sweden found that they would probably not manage to settle safely on a farm of their own. Other men were sons of the landless population and had small chances to move upwards socially. These men (and women in the same generation) went as servants from one place to another, some of them ending up in urban areas with equally small opportunities for social advancement or even a steady job. The skills and norms they were accustomed to do not fit very well to the new circumstances. Marriage was postponed due to the lack of basic means. Many females had their first child outside marriage without fathers who wanted to take the responsibility for their offspring. The men had difficulties to fill the central traditional role as breadwinners. Local supportive informal networks and social control were not as strong in the urban, more anonymous, milieu. Women seemed to be able to handle this better, even if many spinsters and widows had to rely on the meagre supply of poor relief already in their forties. The parallel humps in male surplus mortality and in deaths caused by acute alcohol intoxication in early-nineteenth Sweden in *Figure 4* are striking, but certainly not a coincidence. They are probably just showing the tip of an iceberg with direct or indirect effects of harmful male lifestyles.

- *These negative effects, even when change is positive in the long run, have sometimes been summarized as "social stress".*

In the contemporary affluent part of the world, social stress has become a popular label for the negative psycho-social effects of a person's inability to cope with a situation where external demands and internal aspirations and hopes are not satisfied at work or in general. Social stress has, however, also been used as a diagnosis for societies where rapid social change make these tendencies endemic and can no doubt be used in that sense even to describe historical examples.

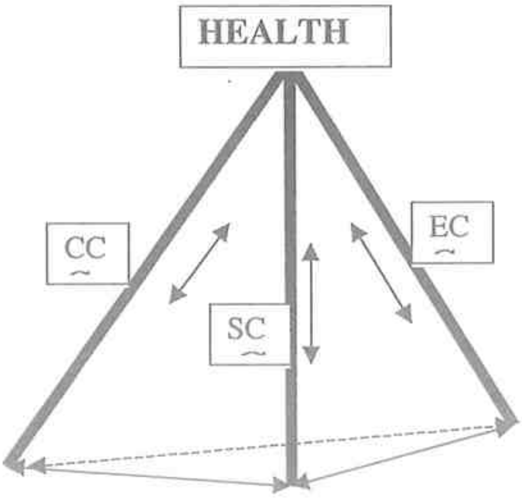
- *The impact of change is always filtered through formal and informal institutions.*

Formal and informal institutions are creating the rules of the social life, hence having an impact on welfare and health. Some institutions are, directly or indirectly, established in order to minimise social dysfunctions such as poverty, health risks and social problems in general. The way these institutions function decides the potentials to strengthen the resources that are essential for welfare or to counter negative effects of social change. Much changed during the Swedish transition from the old "peasant" world. But other traditions survived or developed, some to the benefit of the people's health. Ideas emanating from Enlightenment that disease could be fought with empirical knowledge and prevention prevailed and were realised in several ways. Slowly, the number of district physicians grew in order to serve a sparsely populated country. They were assisted by a new type of midwives, trained and "indoctrinated" in order to teach breast-feeding and childcare. Mass vaccination against smallpox was quickly introduced in the first years of the nineteenth century. The success of this campaign was possible because of the support of efficient parish administrations, headed by the vicar in collaboration with the local elites. Campaigns for cleaner cities – advocated by physicians – were slowly accepted by the city magistrates, which decreased the risks of gastro-intestinal infections and increased life-chances for infants.

These are interventions by the state as a local and central agent for health, forcing the mortality curve downwards. But why did this bring down mortality among adult women but not among men? The most plausible explanation is that the female gender role was more flexible in the face of social problems. One issue, which remained unsolved until the era of industrialisation and emigration in the second half of the century, was what contemporary observers called "the social question". It represented unemployment, poverty, uprooted communities and social conflicts, something that women in certain respects coped with better than men. One of the potential factors that may have been to the advantage of women, due to their gender roles, is "social capital". This term is used in many different contexts with different definitions and connotations. Below, it is primarily seen as resources emanating from people's belonging to, ability to invest in, and capitalise support and safety from close human relationships.

- *Informal institutions – as voluntary associations, social networks in the workplace or among neighbours, the family, and other primary groups – and the way civil society functions are essential for social stability and security.*

Figure 5. *Health, economic capital (EC), cultural capital (CC) and social capital (SC).*



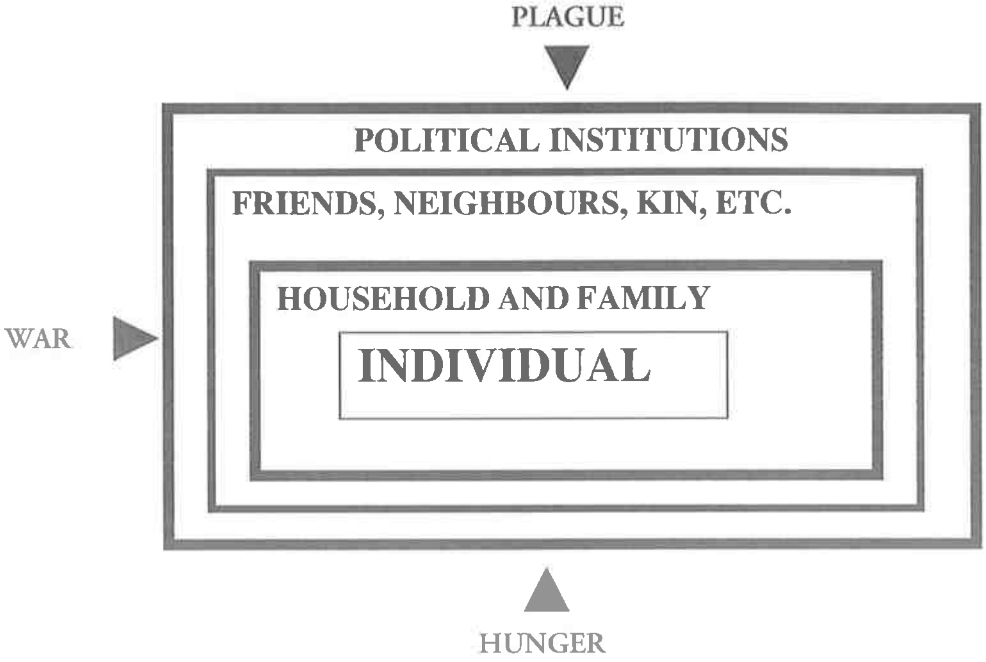
- *"Social capital" is one factor that determines who will become winners and losers.*

Although money and its material equivalents to some extent are necessary assets and solve many resource problems, it is not the only means for safety, welfare and health. What has been called '*social capital*' – in its different definitions and appearances – can be a positive resource to uphold and restore health. This concept can be used both/either as an individual or a collective resource. It may carry more or less weight and importance in specific cases. Although it has an impact both for rich and poor, it is logical to assume that social capital is particularly important for the welfare and health of those who are vulnerable and living close to the limit of material necessity. Pierre Bourdieu's distinction between cultural and social capital and his emphasis on the possibility to exchange one type of capital for another is illustrated in the model of three pillars (types of capital) supporting health in *Figure 5*. The inter-relationship between the four corners of the pyramid is important. Strengthening or weakening one of the four corners has positive or negative impacts on the strength of the other three. This model must of course be used specifically for each context and often analysed separately for men or women.

- *Public institutions can distribute and redistribute material resources, welfare, and social capital.*

This introduces the crucial role of politics, policy and political institutions in the shaping of welfare and health for individuals and the people. It is evident that informal networks, guilds, and other non-state institutions have been essential for people's safety in the past. Yet, even if persons and groups had to handle these things within a less organised state in *l'ancien regime* Europe, historians have increasingly found that there were already by then a number of such tasks taken care of by local political bodies, a form of early "linking social capital", where the elite tries to enhance the social resources of its citizens. The welfare state signifies the ambitious attempt to realise this vision. The role of public institutions during social change is a challenging task. Equally, political change and dismantling or building new institutions may be the spark changing the social fabric. In extreme systems – for instance the apartheid state – institutions reinforce political, economic and social inequality and thereby inequality in health. In a crude sense, it is of course true that our societies have changed from a community based "Gemeinschaft" with strong close links between individuals to a "Gesellschaft" with formal institutions taking care of our needs. It is, however, also true that the community model has never been completely wiped away. Further more, a blend of the two models is probably optimal. The community needs a protective and benevolent state and the state will function badly if the community is weak. *Figure 6* illustrates the strong Gemeinschaft-Gesellschaft attacked by three classical threats to health.

Figure 6. *The strong society – strong community model*



Conclusion

Social change is the changing conditions for fulfilling certain vital goals in life, above all those related to safety – materially and psychologically. Economic resources are created within a certain mode of production (not necessarily referring to Marxist theory). In the human society, the distribution of these resources is organised within a social system, created by norms, rules and institutions. The mode of production has implications for the social system, like a certain social system has implications for the way economic resources are/can be produced. Political change may change the rules and conditions for both economic and social systems. We are sometimes unable to decide if there is a casual chain of events leading to the outcome, at other times economic or political change have obviously come first. *Table 1* lists factors observable in nineteenth-century Sweden and in contemporary Russia and South Africa. The contexts are indeed far away from each other in time and space, and yet we can identify similar patterns.

Two provisional "scenarios" are presented in *Figures 7 and 8*. They give a "reductionistic" picture of relations between health and social change in nineteenth-century Sweden and contemporary South Africa. These scenarios are not deducted from a pretentious theory. They are rather empirically based arguments for comparative analysis of the way social systems function in periods of change.

Amongst other worthy things, it is necessary to increase our understanding of who become winners and who become losers in the perpetual distribution and re-distribution of resources for human welfare and health.

Therefore:

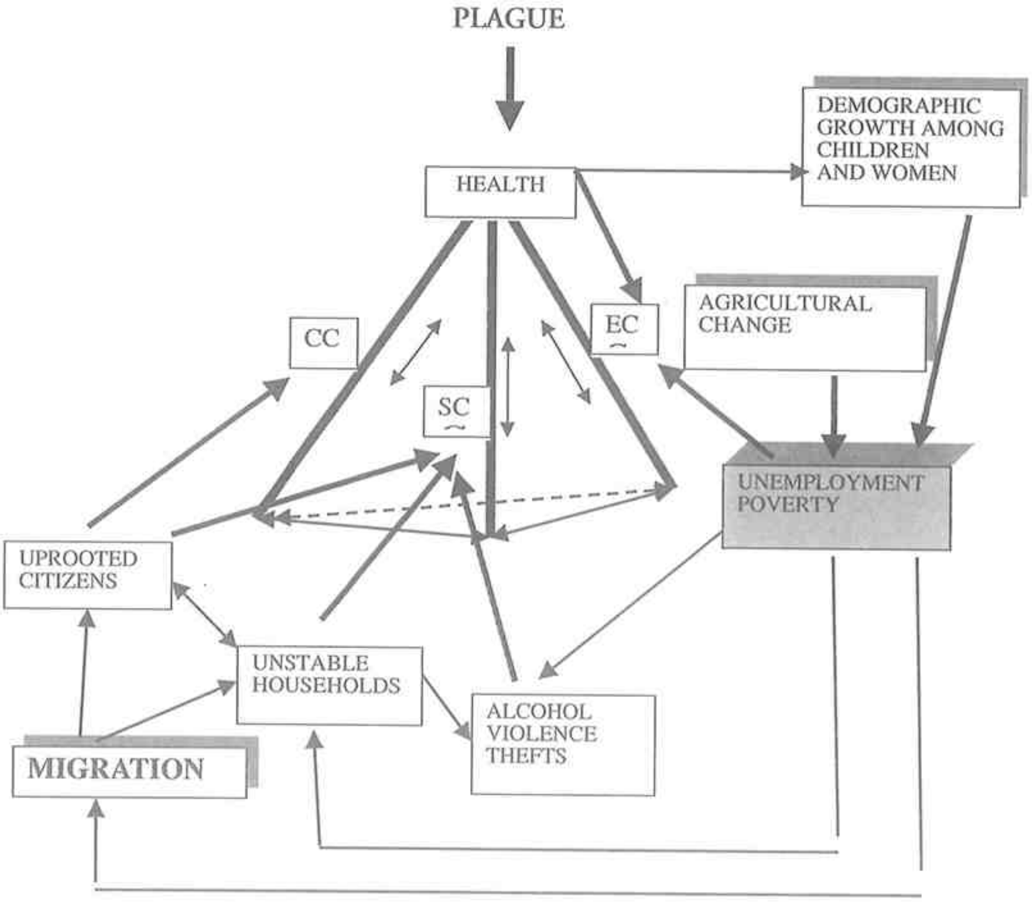
- It is necessary to acknowledge the complexity of context-dependent factors in an analysis of health and social change. Single observations of statistical correlations between a few variables may put the attention to intriguing questions. Used for simplified answers they could be more misleading than enlightening.

- However, even in complex cases, reality must be reduced and the most important elements and events must be identified. Provisional scenarios, based on the experience of other events with similar patterns, are one of the ways. Neither over-simplification nor ad hoc explanations help us to real understanding.

Table 1. *Factors connected with health and social change in 19th century Sweden and Russia and South Africa today.*

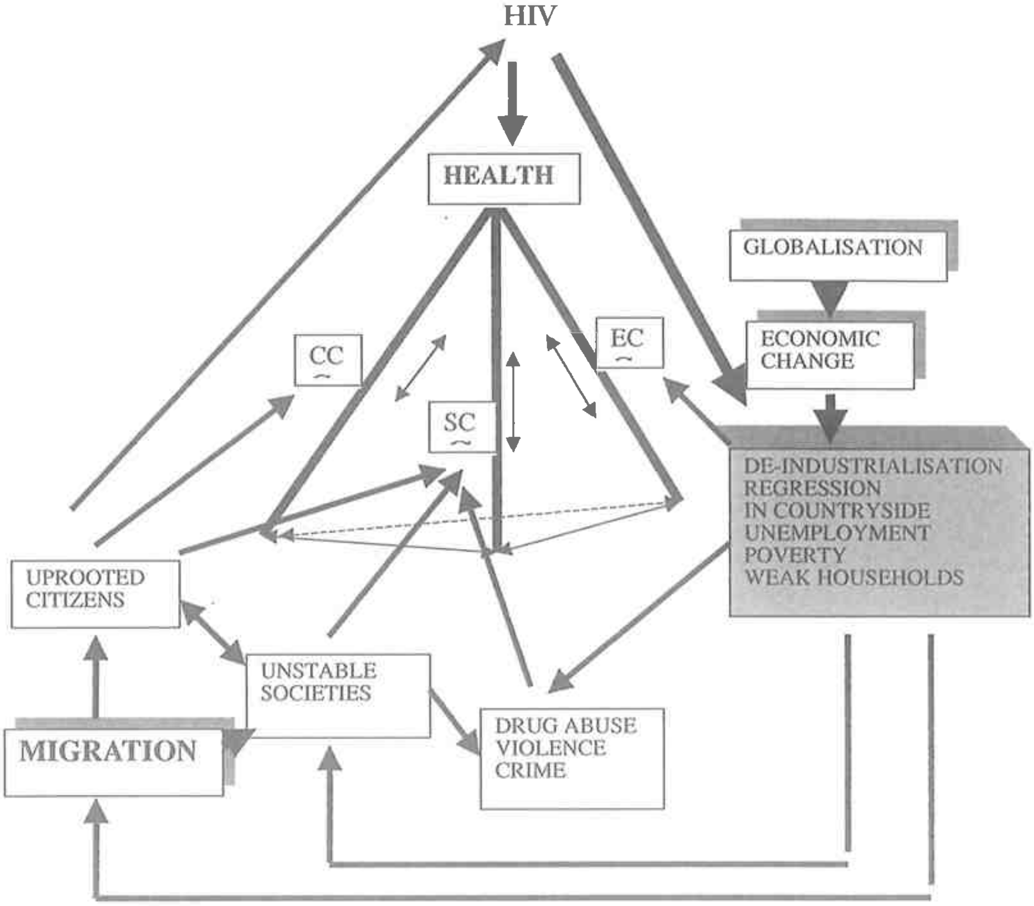
Factor	19th C. Sweden	Russia	RSA
Political change	Moderate	Yes	Yes
Economic & Social Change			
Changes in production	Yes	Yes	Yes
Changes in agriculture	Yes	Yes	Yes
De-industrialization	No	Yes	Yes
Employment crisis	Little industrialisation	Yes	Yes
Pauperisation	Yes	Yes	Yes
Increased inequality	Yes	Yes	Yes
Welfare provision crisis	Yes	Yes	Yes
Demographic Change			
Population size	Up	Stable?	Stable?
Migration to cities	Yes	Yes	Yes
Infant & child mortality	Down	Stable>up	Stable>up
Adult female mortality	Down	Stable	Up
Adult male mortality	Up	Up	Up
Family/household structure	Crisis	Crisis	Crisis
Epidemiological change			
STD's/HIV	STD's high	HIV up	HIV up
Tuberculosis	High	Up	High>up
Other infectious diseases	High>down	Low>up	High>?
Health differentials			
By gender	Yes	Yes	Yes
By marital status	Yes	Yes	Yes?
By class/ethnicity/"race"	Yes	Yes	Yes
By region	Yes	Yes	Yes
Urban/rural	Yes	Yes	Yes
Socio-cultural change			
Uprooted societies	Yes	Yes	Yes
Norm crisis	Yes	Yes	Yes
Social losers'	Yes	Yes	Yes
Abuse of alcohol and drugs	Up	Up	Up?
Violence	Up	Up	Up?
Juvenile delinquency	Up	Up	Up?
Other crimes	Up	Up	Up?
Summary			
Political change	Moderate	Yes	Yes
Economic & social change	Yes	Yes	Yes
Demographic change	Yes	Yes	Yes
Epidemiological change	Yes	Yes	Yes
Health differentials	Yes	Yes	Yes
Socio-cultural change	Yes	Yes	Yes

Figure 7. *Health and social Change – Sweden c. 1800-1850.*



EC = economic capital
CC = cultural capital
SC= social capital

Figure 8. *Health, capital and social change: South Africa 2002*



EC = economic capital
CC = cultural capital
SC= social capital

REFERENCES

Barbarin,O. *Mandela's children: growing up in post-apartheid South Africa.* N.Y. Routledge 2001.

Bobak, M. et al., Socioeconomic factors, percieved control and self-reported health in Russia. A cross-sectional survey. *Soc Sci Med* 1998;47:269-279.

Bond, P. *Elite transition: from apartheid to neoliberalism in South Africa.* London: Pluto 1998.

Bourdieu, P. Le capital social: notes provisoires *Actes de la Rechercheen Sciences Sociales 31* (1980), 2-3.

Bourdieu, P. The forms of capital, *John G. Richardson (ed), Handbook of Theory and Research for the Sociology of Education*, p. 241-158. New York: Greenwood 1985.

Brändström, A. and J. Sundin (eds), *Tradition and Transition. Studies in microdemography and social change.* Report no. 2 from the Demographic Database, University of Umeå 1981 (1).

Brändström, A. and L-G Tedebrand (eds), *Health and Social Change. Disease, health and public care in the Sundsvall district 1750-1950.* Report no. 9. The Demographic Data Base, Umeå University 1993.

Brändström, A. and L-G Tedebrand (eds), *Swedish Urban Demography During Industrialisation.* Report no. 10. The Demographic Data Base, Umeå University 1995.

Brändström, A. S. Edvinsson, and J. Rogers. Illegitimacy, Infant Feeding Practices and Infant Survival in Sweden 1750–1950. A Regional Analysis. *Hygiea Internationalis.* Vol. 3 (2002) http://www.ep.liu.se/ej/hygiea/

Cockerham, W. *Health and Social Change in Russia and Eastern Europe*, New York: Routledge 1999.

Cornia, G. A. and R. Paniccià (eds), *The Mortality Crisis in Transitional Economies.* Oxford U. Press 2000.

Dasgupta, P. and I. Sergaldin, (eds), *Social Capital. A multifaceted perspective.* World Bank 2000.

Durkheim, É. *Le suicide.* Paris : Presses universitaires de France 1991.

Field, J. and T. Schuller, (eds), *Social Capital: critical perspectives* (Oxford: Oxford U. Press 2000).

Gittell, R. and A. Vidal, *Community organisation: building social capital as a development strategy.* London: Sage Publications 1998.

Goldman, N. Marriage Selection and Mortality Patterns: Inferences and fallacies. *Demography* 30(2): 189-208, 1993.

Hawe, P. and A. Shiell, 'Social capital and health promotion: a review.' *Social Science of Medicine* 2000: 51:871-885.

Hertzman, C. and A. Siddiqi, Health and Rapid economic change in the late twentieth century. *Social Science of Medicine* 51, 2000.

Hofsten, E. and Hans Lundström,. *Swedish Population History. Main Trends from 1750 to 1970.* Stockholm: Liber 1976.

Högberg, U. Maternal mortality in Sweden. *Umeå University medical dissertations. N.S. 156.* Umeå University1986.

Jaffrey, Z. *AIDS in South Africa: the new apartheid.* London: Verso 2001.

Johansson, S. R. Welfare, Mortality and Gender. Continuity and Change in Explanations for Male/Female Mortality over Three Centuries. *Continuity and Change*, 6:2, 1991.

Kawachi, I. et al. *The Society and Population Health Reader. Vol. I Income inequality and health* N Y: The New Press 1999.

Kisker, E. E. and N. Goldman, 'Perils of Single Life and Benefits of Marriage'. *Social Biology* 34: 135-152, 1987.

Leon, D. & G. Walt (eds), *Poverty, inequality and health. An international perspective.* Oxford U. Press 2001.

Lindh, T. and B. Malmberg, *Population change and growth in the Western world, 1850-1990.* Working paper for SSHA Conference 2000. http://www.nek.uu.se/faculty/lindh/Recent.html

Lundh, C. The World of Hajnal Revisited. Marriage Patterns in Sweden 1650-1990. *Lund Papers in Economic History* 60. Lund: Department of Economic History, University of Lund 1997.

Macinco, J. and B. Starfield, The utility of social capital in research on health determinants. *The Milbank Quarterly,* 39:3, 2001.

Marmot, M. and R. Wilkinson, *Social determinants of health,* Oxford U. Press 1999.

Nelson, M. C. and J. Rogers, The Right to Die. Anti-vaccination Activity and the 1874 Smallpox Epidemic in Stockholm, *Social History of Medicine,* 5, 1992.

Nelson, M. C. and J. Rogers, Cleaning Up the Cities: The First Comprehensive Public Health Law in Sweden, *Scandinavian Journal of History* 9:2, 1994.

Nelson, M. C. Dirt, Disease and Demography. Public Health and Infant mortality in Uppsala, 1861-1895. M. C. Nelson and J. Rogers, The epidemiological transition revisited. Or what happens if we look beneath the surface? *Health Transition Review* 7:2, 1997.

Nordenfelt, L. *On the nature of health.* 2nd ed. Kluwer Academic Publishers, Dordrecht 1995.

Porter, D. *Health, Civilization and the State. A history of public health from ancient to modern times,* London: Routledge 1999.

Putnam, R. D. *Bowling Alone. The collapse and revival of American Community* (New York: Simon and Schuster 2000).

Rotberg, R. I. (ed), *Patterns of social capital: Stability and change in historical perspective.* Camb. U. P. 2001.

Rothstein, B. Social Capital in the Social Democratic State. The Swedish Model and Civil Society. *Politics and Society* 29, 2001.

Sampson, R. J. and J. D. Morenoff, Public health and safety: community and social capital. V. Shkolnikov et al., Causes of the Russian Mortality Crisis: Evidence and Interpretations. *World Development,* 26, 1998.

South African Health Review, 1999-2002.

Shkolnikov, V., G. Cornia, D. L. Leon and F. Meslé, 'Causes of the Russian Mortality Crisis: Evidence and Interpretations'. *World Development,* 26, 1998.

Sköld, P. *The Two Faces of Smallpox. A Disease and Its Prevention in Eighteenth- and Nineteenth-Century Sweden.* Report no. 12 from the Demographic Data Base. Umeå University 1996.

Studies on the social dimensions of globalization. South Africa. ILO 2001.

Sundin, J. Environmental and other factors in health improvement explaining increased survival rates in 19th century Sweden. *Erik Nordberg and David Finer (eds), Society, environment and health in low-income countries.* Department of International Health Care Research, Karolinska institutet, Stockholm 1990.

Sundin, J. Culture, Class and Infant Mortality During the Swedish Mortality Transition, c. 1750-1850. *Social Science History,* 19:1, Spring 1995.

Sundin, J. Child Mortality and Causes of Death in a Swedish City, 1750-1860. *Historical Methods* 1996, 29:3: 93-106.

Sundin, J. For God, State and People. Crime and Local Justice in Pre-Industrial Sweden. In: Johnson, E. and E. Monkkonen (eds), *The Civilization of Crime. Violence in Town and Country since the Middle Ages*. University of Illinois Press, 1996.

Sundin, J. Worlds We Have Lost and Worlds We May Regain: Two Centuries of Changes in the Life Course in Sweden. *The History of the Family. An International Quarterly*, Vol. 4:1, 1999.

Sundin, J. Globalisation, Social Change and Health. A diachronic Perspective. *Towards a Safe and Civil Society. The Contributions of Occupational and Environmental Health and Safety in History, Theory and Practise. Proceedings of ICOH Conference September 2000*, Brisbane 2000.

Sundin, J. Individual Change or Environmental Reform? Historical Perspectives on Responsibility and Hygienism. In: *Bourdelais, P. (ed), Les Hygiènistes. Enjeux, modèles et pratiques*. Paris: Belin 2001.

Sundin, J. and S. Willner (eds.) *Samhällsförendring och hälsa. Olika forskarperspektiv*. Rapportserien Framtidsstudier, no 7. Stockholm 2003.

Szreter, S. Economic Growth, Disruption, Deprivation and Death: On the importance of the Politics of Public Health for Development. *Population and Development Review*, 23:4, 1997.

Szreter, S. The state of social capital: bringing back in power, politics and history. To be published in *Theory and Society*,2003.

Söderberg, J. U. Jonsson and Ch. Persson, *A stagnating metropolis: the economy and demography of Stockholm, 1750-1850*. Cambridge 1991.

Wilkinson, R. (ed), *Why society kills*. London: Routledge 1996 (1).

Wilkinson, R. *Unhealthy societies: the afflictions of inequality*. London: Routledge 1996 (2).

Willner, S. The impact of alcohol consumption on excess male mortality in early 19th and 20th century Sweden, *Hygiea Internationalis*, 2, 2001. http://www.liu.se/tema/inhph/journal/default.htm

Woolcock, M. *Using social capital: getting the social relations right in the theory and practice of economic development* Princeton 2002.

Key note speaker, professor Claudine Herzlich and professor Patrice Bourdelais, both from Paris, at the Oslo conference, (Photo Ø. Larsen)

Claudine Herzlich

Health and illness at the dawn of the 21st century: From private experience to the public sphere and back

Michael 2004; 1: 163-171

According to the French anthropologist Marc Augé (1984), "The very paradox of the experience of illness is that it is both the most individual and the most social of things." It is also difficult to discern whether health and illness belong more to the private or public domain. The bounds between these two domains are not immutable and have often shifted about in the fields of health and illness. Nonetheless, the body still belongs to the private domain. Although the era when religious traditions made a taboo out of the body is now far past, its sensations are still matters of intimacy, even secrecy and personal everyday rituals. Paying attention to bodily states is an activity involving primary relationships, the family still being deeply involved in preserving health and providing care. Moreover, health and illness affect many fields of private life, especially love and sexuality. About the AIDS epidemic in Africa, van Nieberk (2002) has stated that among its effects has been "the brutalisation of intimacy itself". In societies with harsh living conditions, sexuality remains

> "one of the few avenues of intimacy and of an accompanying sense of self-worth and dignity [...] That is until AIDS appears on the scene. Now [...] a disaster not only lurks in the sphere of the public where [...] one is almost predisposed to expect it, but exactly in the remaining sphere where one might have hoped to retain some measure of control and dignity: the private and the intimate."

We cannot talk about bodies, illness and health without relating them to the public domain too. The history of health is also a history of states and cities, of work, of wars and travels. Historians and sociologists have, for a long time now, been analyzing care-giving institutions and health policies, tracing the evolution of epidemics and describing major phases in "collective health". Most of us thought we were explaining an irreversible trend. As the welfare state took shape, health would turn into a political issue; and the "sick man" vanishes under the scrutiny of science. As a consequence, for a long time, we neglected looking at health and illness as private, personal experiences.

Since then, however, many studies have focused on this private aspect and examined "first-person" narratives by the ill or persons close to them, but as often happens, research is following a trend in society. Individuals' experiences of health and illness are not being reported in scientific journals alone. Patients are raising their voices and using their experiences as arguments to be taken into account when drafting health policies. I would like to analyze how have our academic disciplines become interested in the private and personal experience of health and illness and have dealt with its presence, or absence, of the public space.

The case of sociology is exemplary. With the growing awareness of an unprecedented expansion of medicine, sociologists started working in the field of health during the decades following WW II. The so-called "biomedical model" had acquired an incontrovertible legitimacy for explaining and treating illness conditions. By raising questions about this, Talcott Parsons (1951) inquired into the social meanings of health and investigated medicine's role not just as a set of techniques but also as a means of social control and regulation. In his wake, sociologists did not analyze health and illness as private or public realities but, instead, considered them to be phenomena defined by "professionals" and left up to medicine and doctors. During a first phase in this new field of research, sociologists mainly looked at illness as a "social role" and at patients as consumers of health care who follow doctors' prescriptions.

Then during the 1970s, a more critical view arose. Social scientists criticized the increasing "medicalisation" and "social control" that medicine was exercising over bodies. Behind medicine stood the state, imposing its normative goals on people and their health. In line with Michel Foucault's ideas, Armstrong (1995) decried the advent of a "surveillance medicine", which was reshaping not just the illness experience and the attention paid to bodies but also senses of identity. During the first years when this critical view of medicine and the state was taking shape, sociologists mainly mentioned private individual experiences in order to accuse and lament that medicine was keeping us from hearing an authentic "patient's voice".

The critical spirit of the 1970s permeated all spheres of social activities. The women's movement took shape around demands concerning the body and the refusal of its "medicalisation". The "patient's voice" thus became audible in society and became a subject of research in the social sciences. These disciplines gradually showed interest in topics such as gender, the body and emotions. Such research drew even more attention toward the private experience of illness. My first study in this field, published in 1973, tried to take into account people's views about health and illness. My assumption being that what people had to say on these topics could be studied in its own right. Even when they refer to medicine and doctors, we should not see them as "dominated" by an all-powerful medical model. Patients' "discourses" about health and illness recount personal, private experiences that are, however, "socialized". They shed light on the relations between the individual and his/her group in the specific biographical context of illness.

This growing interest with the personal, the private and the everyday took place in a general trend in the social sciences. Norbert Elias (1978) was among the first to point out that this fascination was linked to the rise of new theoretical stances and the rejection of the major paradigms, like Marxism, that had, till then, explained collective life and the future of societies. Later, François Dubet (1994) wrote that, given its "abandonment of the classical conception of society as an order", sociology now has as its central concern "the social experience", which refers to "the work that each of us performs on ourselves" to be the author of his/her own life. This requirement of work on one's self is precisely what characterizes the illness experience. By the 1980s, more and more sociological studies, on the basis of qualitative data collected by semi-directive interviews, were focused on the illness experience of lay people.

History was taking a parallel path. Private life was becoming a legitimate subject for historians (Ariès & Duby 1987). Meanwhile, the so long overlooked history of patients has become a stimulating field of research as "ego-documents", in particular the letters patients sent to persons close to them or to doctors, are being discovered and examined.

This evolution in intellectual and ideological positions intersected an evolution in pathology. Ever more attention was being paid to the prevalence of chronic and "degenerative" conditions in modern societies. These long-term illnesses, since they affect all aspects of a patient's life, required a shift away from a model of health care centered on acute illnesses. As Armstrong (1984) and others have pointed out, doctors themselves had to bring the patient's life and the "patient's view" back into their understanding of chronic illness. In this new context, social scientists interested in the private, personal aspect of the illness experience turned to studying chronic illnesses. To a degree, especially in relation with medical circles, they became spokespersons for the chronically ill who had limited visibility in the public sphere and were overlooked by the mass media and neglected by health policy.

This research has made an important contribution to the sociology of health and illness[2]. It has shed light on everyday life "with and in spite of illness" and shown how illness affects patients' identities. Unlike in an acute illness, which but temporarily interrupts daily life, sociologists have detected in the private experiences of the chronically ill evidence of an irreversible destabilization: the unforeseeable succession of "good" and "bad days" (Charmaz 1991), the long-term disruption of daily routines, and the need to reexamine the usual behaviors, "tacit assumptions" and empirical knowledge that underlie the individual's existence as well as his/her life in the family and at work. By studying these various disruptions, we have undertaken an in-depth investigation of the "everyday social order", of how fragile it is in relation to biological factors and how difficult it is to reorganize everyday life. In this way, long overlooked "bodily facts" have found a place in the social sciences.

The analysis of the meanings given to the illness experience by the persons who have to cope with it has clearly shown how important the body is to a sense of identity. Researchers have listed the changes in self-esteem brought by chronic illness: feelings of shame related to the body's deteriorating state, the "stigma" felt in encounter with others, and the patient's sense of a "loss of self". For Michael Bury (1982), a long-time illness implies "a fundamental re-thinking of the person's biography and self concept". Thanks to his concept of a "biographical disruption", the accent shifted toward the illness experience's temporal dimension and the "reflexive" work performed by patients who seek, not always successfully, to regain control over their lives.

After having seen their positive contributions, let us take a critical look at these studies. First of all, it should be pointed out that sociology has explored but a part of the possible range of illness careers. And, as Lindsay Prior (2003) has recently noted, the acute illness experience, especially during critical phases, has gone unnoticed. We have also neglected the experiences of epidemic, infectious and parasitic diseases in Third World countries. Furthermore, few studies have examined other bodily events, and then only of women's experiences (menstruation, abortion and breast-feeding). Secondly, despite the increasing importance given to health in contemporary societies, and despite the heavier emphasis placed on "lifestyles" that is transferring the responsibility for health from the public to the private domain, sociologists have conducted few studies on bodily well-being and fitness. They have studied health perceptions and behaviors, not health experiences from the personal viewpoint of the concerned. This "emic" study of health would be important both in itself and for an understanding of illness. For example, we might suppose that the ever tighter linkage between health and self-esteem worsens the sense of a "loss of self" felt by the chronically ill.

Thirdly, as Janine Pierret (2003:14-15) has noted in her recent review of this field, research on the illness experience has barely inquired into the macro-social context and has not sufficiently analyzed the relations between private, everyday experiences and the structural factors affecting them. To cite just an example, the stigma felt by the ill or disabled and, too, the recognition of their rights both provide evidence about a society's policy options and about social bonds in that society. Health and welfare policies, as well as the funding of the health-care system and social security systems, are crucial not only to patients' medical prospects and their access to health and medical services, but also to their lives and everyday experiences. But these relationships have certainly not been analyzed in depth in our studies.

By the 1990s, researchers were focusing on a new subject, namely first-person illness narratives. Once again, sociologists of illness were swept up in a current running through the social sciences, a current of interest in narrativity. The history of literature has a tradition of diaries, letters, personal accounts and novels centered on illness. Nowadays, such narratives, whether spontaneous or produced in the framework of sociological research, increasingly fascinate sociologists studying illness. Every issue of journals in this field now contains one or more articles on this theme; and the notion of narration has become a key concept (Hyden 1997).

There is no denying that many of the scientific studies of these narratives are both interesting and moving. The personal viewpoints thus expressed are a far cry from the descriptions and conceptions of biomedicine. And we notice how emotionally close social scientists frequently have been to the patients whose narratives they have analyzed. Nonetheless, I sometimes feel uncomfortable with the stance adopted by these authors. First of all, narration is not neutral; it is always destined for someone and pursues an underlying goal. But sociologists have sometimes accepted narratives "at face value" and too easily assumed that they convey an image "truer" than what any other method of inquiry could produce. The key role assigned to narration as a discursive process has also, despite references to the body and to suffering, tended to "de realize" the illness experience: in these studies, illness becomes a "text" with a meaning but without any reality or material import.

For some researchers, the major quality of these narratives is their moral dimension, since illness is a "moral occasion" (Frank 1997) that crystallizes "vital lessons about living" (Charmaz 1991). This perspective on illness is the diametrical opposite of the vision emerging from studies of the chronically ill coping with everyday life. The personal experience of illness is no longer a "biographical disruption"; it no longer entails a "loss of self". Instead, it is a self-discovery, it offers a possibility of renewal and change, or the opportunity for proving one's capacity to "rise to the occasion" and "be successfully ill". The patient is thus presented as a major figure in our contemporary individualistic culture. No one can deny that illness, like any other important life-event, is a "moral experience" that can have positive aspects. In fact, this idea fits in a long tradition of religious interpretations of illness. But can all illnesses be "successful"? Does this model of personal salvation through illness not put intense pressure on patients who feel unable to "succeed" in that way?

Moreover, how can we make these rather discordant images of the patient's private, personal experience compatible with each other? If sociological research is to advance, it must start taking this diversity into account and explaining it. It must, above all, become more reflexive and critical of its own methods and actions. How do methods of data collection, the context of research and the implication of the sociologist whether as spokesperson or witness, influence patients' narratives and, more generally, the kind of data we are able to collect?

Nevertheless, these various currents of research share common points. Both of them have certainly helped to bring visibility to the private experience of illness, by emphasizing its individual and subjective dimension in isolation from the social context and the domain of collective public life. Undoubtedly, these analyses have reflected a common conception of modern chronic illnesses: as "totally turned inward the individual (...) and not discernible in the public space" (Herzlich, Pierret 1987). But they failed to recognize that the private is not isolated from the public and the collective, and is not severed from socio-historical trends. However, the breakout AIDS came to provide another frame of interpretation for illness, its experience and narratives. Given its epidemic character and that it initially spread in certain groups, AIDS soon became a public, collective phenomenon.

The narratives produced by the HIV-positive ranged, from the very start, well beyond the individual, subjective domain. These persons declared they were talking not in their own name alone but also for the sake of other patients and of the groups where the epidemic was hitting hardest. These narratives thus amounted to testimonies with several objectives. They expressed a sense of identity, but the self-work entailed by the illness experience referred to the possibility of fitting one's individual life-trajectory into a group history. The narrators also wanted to change the negative image of the illness and fight against stigmatization. This strategy was effective. At the start of the epidemic, when the public only heard reports that alarmingly tallied the ever increasing number of anonymous victims, the temptation was strong to react with coercion. As of 1985, persons with AIDS were talking about their lives and situation, and were seen on television. The inclination to discriminate against them decreased, and feelings of compassion and solidarity arose in other groups. Bearing testimony in this way was one of the first public manifestations of the activist organizations forming to fight against the epidemic. Thanks to all this, patients' private experiences were widely diffused through the media toward the public; and personal narrations were part of the effort to stimulate collective action. The AIDS illness experience thus became a public issue.

This set off a trend reaching far beyond AIDS. Ever more often for various sorts of health problems, a new kind of patients appeared in the public space. Patients' associations about various other illnesses make them heard and their voices have a per formative impact. Their narratives are not just testimonies. They might take the form: of complaints as in lawsuits; and often, of warnings as in recent "health crises" (such as mad cow disease or asbestosis); or even of accusations against political authorities and economic interests. In all these cases, groups form that effectively rally people on the basis of a personal experience.

Researchers who studied the AIDS epidemic (including myself) were fascinated by this sudden emergence of the illness experience in the public domain. The considerable sociological research devoted to AIDS has clearly shown how the private and public domains of life overlap and how intimacy becomes collective and political. As social scientists, we did not assume the role of spokesman for patients, since the latter have managed on their own to make themselves heard. Instead, we became their allies. We were attracted by this new figure of the patient on the social scene and especially by the solidarity and activism of persons with AIDS and their organizations. Suddenly, Parsons' idea that the ill are denied the possibility of forming a group seemed definitively outdated. On the contrary, patients now seemed to serve as the best example of contemporary collective action and activism. We assumed we were observing a "change of paradigm": the advent of patients' power and a radical transformation in our societies' relation with health, medicine and science. Health was becoming a key issue, a news topic (Herzlich, Pierret 1988), drawing the attention of the media and politicians. Through activists in organizations, "civil society" was forcing its way into hospitals and laboratories. The relations these activists established with medicine and science were both critical and participatory. The "patient's viewpoint" was being used to create new civil rights.

But the AIDS epidemic is now 20 years old. How should we appraise the evolution and take stock of the current situation? It is time to ask the question: has AIDS deeply changed the relations between the public and private in the field of health? Has it irreversibly changed people's relations with medicine? In poor countries, AIDS is now a huge pandemic menacing not just lives but also economic development and social cohesion. The voices of patients there are barely audible. In wealthy countries, mobilization around AIDS has, since treatments have become efficacious, fallen off. The patient no longer holds centre stage. Nowadays, many patients are, again, left in the solitude of their individual experience.

Did social scientists overestimate changes during the past two decades? Did we fail to recognize that social change is never homogenous nor linear? Did we too easily come to believe that they would extend into all fields of health? Should we have paid more attention to other evidence – for example, to some studies showing that most persons with AIDS did not belong to an organization and did not even have contacts with each other? Or the evidence that, in the case of other illnesses, few changes have occurred in the relations with medicine and in the illness experience? In some domains, patients' associations are still hardly visible, rather powerless and they struggle for their existence. Sociologists should be well aware of these neglected realities. For us, the challenge is to analyze this new phase and then reexamine the picture I drew earlier.

Bibliography

Ariès, P. & Duby, G., 1987. *Histoire de la vie privée*, Paris: Seuil.

Armstrong, D., 1984. "The patient's view", *Social science and medicine*, 18(9), pp.737-744.

Armstrong, D., 1995. "The rise of surveillance medicine", *Sociology of health and illness*, 17(3), pp.393-440.

Augé, M., 1984. "Ordre biologique, ordre social: la maladie forme élémentaire de l'événement" in: M. Augé & C. Herzlich (eds.), *Le sens du mal. Anthropologie, histoire, sociologie de la maladie*, Paris: Éditions des Archives Contemporaines, pp.35-91.

Bury, M., 1982. "Chronic illness as biographical disruption, *Sociology of health and illness*, 4(2), pp.167-182.

Charmaz, K., 1991. *Good, days, bad days: The self in chronic illness and time*, New Brunswick, NJ: Rutgers University Press.

Dubet, F., 1994. *Sociologie de l'expérience*, Paris: Seuil.

Élias, N., 1978. "Zum Begriff des Alltags" [On the concept of daily life], *Kölner Zeitschrift für Soziologie und Sozialpsychologie*, 20, pp.22-29.

Frank, A.W., 1997. "Illness as moral occasion: Restoring agency to ill people", *Health*, 1(2), pp.131-148.

Herzlich, C., 1973. *Health and illness, a social psychological analysis*, London: Academic Press.

Herzlich, C, Pierret J, 1987. *Illness and Self in Society*, Baltimore, The Johns Hopkins University Press.

Herzlich, C, Pierret J, 1988. " Une maladie dans l'espace public : le sida dans six quotidiens français", *Annales, Économies, Sociétés, Civilisations*, (5), pp. 1109-1134.

Hyden, L.C., 1997. "Illness and narrative", *Sociology of health and illness*, 19 (1), pp.48-69.

Nieberk, A.A. van, 2002. "Moral and social implications of AIDS in Africa", *Journal of medicine and philosophy*, 27(2), pp.143-161.

Parsons, T., 1951. "Social structure and dynamic process: The case of modern medical practice", chapiter 10 in *The social system*, Glencoe, IL: Free Press.

Pierret, J., 2003. "The illness experience: State of knowledge and perspectives for research", *Sociology of health and illness*, silver anniversary issue, pp.4-22.[1]

Prior, L., 2003. "Belief, knowledge and expertise: The emergence of the lay expert in medical sociology", *Sociology of health and illness*, silver anniversary issue, pp.41-57.

Claudine Herzlich
CERMES (CNRS-INSERM-EHESS)
7 rue Guy Moquet
94801 Villejuif Cedex, France
33 1 4958 3566
herzlich@vjf.cnrs.fr

For: *Health between the private and the public: Shifting approaches*, Sixth EAHMH Conference, Oslo, 3-7 September 2003
Article translated from French by Noal Mellott (CNRS, Paris, France)

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[1] The special 25th anniversary issue of *Sociology of health and illness* carries an interesting review of research in this field by Janine Pierret (2003). This British journal alone has run dozens of articles on the illness experience – not to count the articles in other journals or in books.

PRIVATE PRACTICE OF MEDICINE AND PUBLIC HEALTH
CARE IN CONSTANTINOPLE (330-1453 AD)
Effie Poulakou-Rebelakou
History of Medicine, Athens University Medical School (Greece)

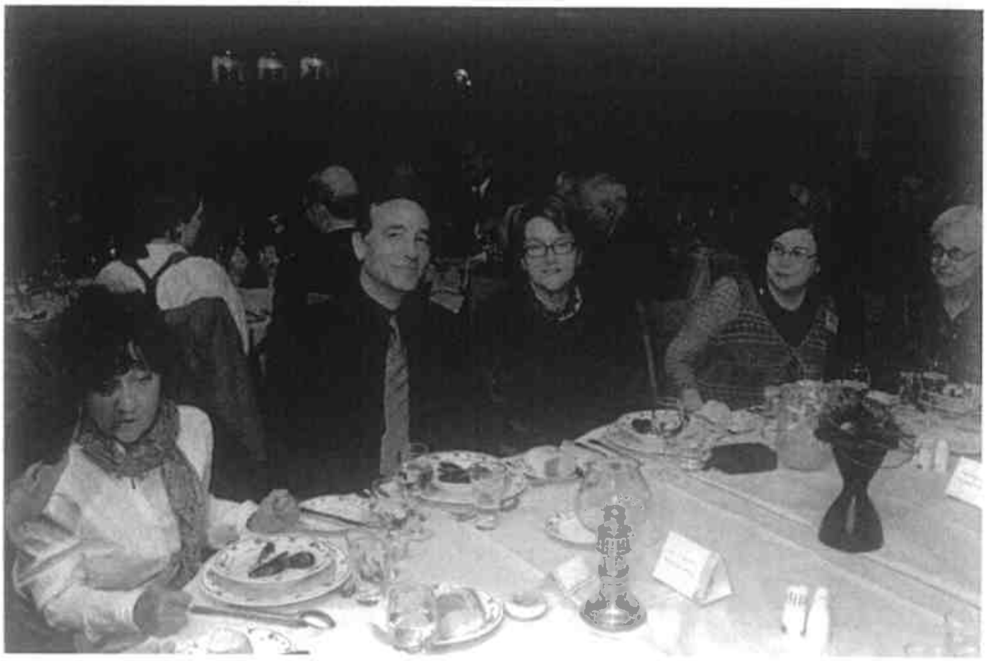
A choice of poster presentations was available. (Photo Ø. Larsen)

Visit to the medical exhibition Stories about health, *which had been arranged by the Foundation National Medical Museum in the main hall of the National Hospital (Rikshospitalet) in Oslo. (Photo Ø. Larsen)*

Brass concert at the dinner on September 5th, 2003. (Photo I.F.Larsen)

Jorunn Mathisen (Norway) presenting a nursing history project. (Photo Ø. Larsen)

The traditional "outing" of the EAHMH conferences went this time to the old silver mining city of Kongsberg and included a visit to tunnels, galleries and shafts carved out kilometers into the rock centuries ago, making the participants acquainted with the abundance of accident and health risks facing the workers in the past. In the old dormitory of the miners, the audience attended The Kongsberg lecture, *which presented a recently discovered archive material on the patients treated by the surgeon of the mining company in the year 1739. This study has been published in Norwegian, containing the Kongsberg lecture (in English) as a summary, in the book Berg BI, Braaten M, Larsen Ø.* Yrkesskader ved Kongsberg Sølvverk. Bergkirurgens skadejournal 1739. *Kongsberg: Bergverksmuseet, Skrift nr. 26, 2004. ISBN 82-91337-30-6. 118 pp. (Photo Ø. Larsen)*



Official farewell dinner on September 6th, 2003: From the left professor Armelle Debru (Paris), professor Esteban Rodrigues-Ocaña (Granada), dr. Ingegerd Frøyshov Larsen (Oslo), professor Marie Clark Nelson (Linköping) and professor Marijke Gijswijt-Hoofstra (Amsterdam). (Photo Ø. Larsen)