

ILLICH, I.; (1976): *Limits to Medicine; Medical Nemesis: The Expropriation of Health*, Marion Boyars Publishers, London.

Ivan Illich is a man of unearthly courage. During the course of his passionate life, he succeeded in drawing upon himself the wrath of institutional educators, corporate technocrats, virtually the entire profession of medicine, and the Vatican itself.

Medical Nemesis represents a work of unimpeachable scholarship, fluid erudition, and fearless rhetoric. This work is an unapologetic assault upon a profession that has gained immense cultural authority by its tacit support of social, political, and economic systems that themselves undermine the health of many who labour under their constraints and directives.

Understandably, this work was not welcomed with open arms by medical orthodoxy. But Illich was no stranger to the consequences of truth-speaking. He was forced out of his own church by too strongly criticising the policies of the Roman curia regarding the management of Central and South American problems. He also had much to say about the problems associated with clerical celibacy. Ivan Illich had a penchant for rocking the boat. Not surprisingly, he found himself cast adrift.

Illich is to be admired for his principled courage and fearless confrontation of forces he perceived as being inherently noxious and damaging to the collective psyche. Illich lived as he spoke. Even in the end, he eschewed the ministrations of oncologists in the treatment of a disfiguring facial tumour that seared his final days, preferring to wear both the pain and the tumour with fortitude and dignity. He remained active until the end, occasionally propped up by lighting a small piece of opium in the pipe that he carried about with him during his final years.

Despite the many alienations of his life, Illich remains inspirational as one who spoke directly to the sickness of his times.

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Introduction

The layman in medicine, for whom this book is written, will himself have to acquire the competence to evaluate the impact of medicine on health care. Among all our contemporary experts, physicians are those trained to the highest level of specialized incompetence for this urgently needed pursuit. p. 6

The Epidemics of Modern Medicine

What had formerly been considered an abuse of confidence and a moral fault can now be rationalized into the occasional breakdown of equipment of operators. In a complex

technological hospital, negligence becomes “random human error” or “system breakdown”, callousness becomes “scientific detachment”, and incompetence becomes “a lack of specialized equipment”. The depersonalization of diagnosis and therapy has changed malpractice from an ethical into a technical problem. p. 30

The so-called health professions have an even deeper, culturally health-denying effect insofar as they destroy the potential of people to deal with their human weakness, vulnerability, and uniqueness in a personal and autonomous way. The patient in the grip of contemporary medicine is but one instance of mankind in the grip of its pernicious techniques. This cultural iatrogenesis . . . is the ultimate backlash of hygienic progress and consists in the paralysis of healthy responses to suffering, impairment, and death. It occurs when people accept health management designed on the engineering model, when they conspire in an attempt to produce, as if it were a commodity, something called “better health.” This inevitably results in the managed maintenance of life on high levels of sublethal illness. This ultimate evil of medical “progress” must be clearly distinguished from both clinical and social iatrogenesis. pp. 33-34

The Medicalization of Life

Social iatrogenesis is at work when health care is turned into a standardized item, a staple; when all suffering is “hospitalised” and homes become inhospitable to birth, sickness, and death; when the language in which people could experience their bodies is turned into bureaucratic gobbledegook; or when suffering, mourning, and healing outside the patient role are labelled a form of deviance. p. 41

When hospitals draft all those who are in critical condition, they impose on society a new form of dying. p. 42

The divorce between medicine and morality has been defended on the ground that medical categories, unlike those of law and religion, rest on scientific foundations exempt from moral evaluation. p. 47

The fundamental reason why these costly bureaucracies are health-denying lies not in their instrumental but in their symbolic function: they all stress delivery of repair and maintenance services for the human component of the megamachine, and criticism that proposes better and more equitable delivery only reinforces the social commitment to keep people at work in sickening jobs. p. 61

Powerful medical drugs easily destroy the historically rooted pattern that fits each culture to its poisons; they usually cause more damage than profit to health, and ultimately establish a new attitude in which the body is perceived as a machine run by mechanical and manipulating switches. p. 63

One doctor in Latin America who was also a statesman did try to stem the pharmaceutical invasion rather than just enlist physicians to make it look more respectable. During his short tenure as president of Chile, Dr. Salvador Allende quite successfully mobilized the poor to identify their own health needs and much less successfully compelled the medical profession to serve basic rather than profitable needs. He proposed to ban drugs unless they had been tried on paying clients in North America or Europe for as long as the patent protection would run. He revived a program aimed at reducing the national pharmacopoeia to a few dozen items, more or less the same as those carried by the Chinese barefoot doctor in his black wicker box. Notably, within one week after the Chilean military junta took power on September 11, 1973, many of the most outspoken proponents of a Chilean medicine based on community action rather than on drug imports and drug consumption had been murdered. pp. 68-69

The age of new drugs began with aspirin in 1899. Before that time, the doctor himself was without dispute the most important therapeutic agent. p. 74

The hospital, the modern cathedral, lords it over this hieratic environment of health devotees. From Stockholm to Wichita the towers of the medical center impress on the landscape the promise of a conspicuous final embrace. For rich and poor, life is turned into a pilgrimage through check-ups and clinics back to the ward where it started. Life is thus reduced to a “span,” to a statistical phenomenon which, for better or for worse, must be institutionally planned and shaped. This life-span is brought into existence with the prenatal check-up, when the doctor decides if and how the fetus shall be born, and will end with a mark on a chart ordering resuscitation suspended. Between delivery and termination this bundle of biomedical care fits best into a city that is built like a mechanical womb. At each stage of their lives people are age-specifically disabled. The old are the most obvious example: they are victims of treatments meted out for an incurable condition. p. 79

Only the very rich and the very independent can choose to avoid that medicalization of the end to which the poor must submit and which becomes increasingly intense and universal as the society they live in becomes richer. p. 84

By turning the newborn into a hospitalized patient until he or she is certified as healthy, and by defining grandmother’s complaint as a need for treatment rather than for patient respect, the medical enterprise creates not only biologically formulated legitimacy for man the consumer but also new pressures for an escalation of the megamachine. Genetic selection of those who fit into that machine is the logical next step of medico-social control. p. 88

The doctor’s refusal to recognize the point at which he has ceased to be useful as a healer and to withdraw when death shows on his patient’s face has made him into an agent of evasion or outright dissimulation. The patient’s unwillingness to die on his own makes him pathetically dependent. He has now lost his faith in his ability to die, the terminal shape that health can take, and has made the right to be professionally killed into a major issue. pp. 102-103

In high culture, religious medicine is something quite distinct from magic. The major religions reinforce resignation to misfortune and offer a rationale, a style, and a community setting in which suffering can become a dignified performance. The opportunities offered by the acceptance of suffering can be differently explained in each of the great traditions: as karma accumulated through past incarnations; as an invitation to Islam, the surrender to God; or as an opportunity for closer association with the Saviour on the Cross. High religion stimulates personal responsibility for healing, sends ministers for sometimes pompous and sometimes effective consolation, provides saints as models, and usually provides a framework for the practice of folk medicine. In our kind of secular society religious organizations are left with only a small part of their former ritual healing roles. One devout Catholic might derive intimate strength from personal prayer, some marginal groups of recent arrivals in Sao Paulo might routinely heal their ulcers in Afro-Latin dance cults, and Indians in the valley of the Ganges still seek health in the singing of the Vedas. But such things have only a remote parallel in societies beyond a certain per capita GNP. In these industrialized societies secular institutions run the major myth-making ceremonies. pp.108-109

Medical procedures turn into black magic when, instead of mobilizing his self-healing powers, they transform the sick man into a limp and mystified voyeur of his own treatment. Medical procedures turn into sick religion when they are performed as rituals that focus the entire expectation of the sick on science and its functionaries instead of encouraging them to seek a poetic interpretation of their predicament or find an admirable example in some person - long dead or next door - who learned to suffer. Medical procedures multiply disease by moral degradation when they isolate the sick in a professional environment rather than providing society with the motives and disciplines that increase social tolerance for the troubled. Magical havoc, religious injury, and moral degradation generated under the pretext of a biomedical pursuit are all crucial mechanisms contributing to social iatrogenesis. pp. 114-115

More and more people subconsciously know that they are sick and tired of their jobs and of their leisure passivities, but they want to hear the lie that physical illness relieves them of social and political responsibilities. They want their doctor to act as lawyer and priest. As a lawyer, the doctor exempts the patient from his normal duties and enables him to cash in on the insurance fund he was forced to build. As a priest, he becomes the patient's accomplice in creating the myth that he is an innocent victim of biological mechanisms rather than a lazy, greedy, or envious deserter of a social struggle for control over the tools of production. p. 123

Cultural iatrogenesis

Professionally organized medicine has come to function as a domineering moral enterprise that advertises industrial expansion as a way against all suffering. It has thereby undermined the ability of individuals to face their reality, to express their own

values, and to accept inevitable and often irremediable pain and impairment, decline, and death. pp. 127-128

Most healing is a traditional way of consoling, caring, and comforting people while they heal, and most sick-care a form of tolerance extended to the afflicted. Only those cultures survive that provide a viable code that is adapted to a group's genetic make-up, to its history, to its environment, and to the peculiar challenges represented by competing groups of neighbors. p. 131

Traditional cultures and technological civilization start from opposite assumptions. In every traditional culture the psychotherapy, belief systems, and drugs needed to withstand most pain are built into everyday behavior and reflect the conviction that reality is harsh and death inevitable. In the twentieth century dystopia, the necessity to bear painful reality, within or without, is interpreted as a failure of the socio-economic system, and pain is treated as an emergent contingency which must be dealt with by extraordinary interventions. pp. 135-136

While rejecting an acceptance of suffering as a form of masochism, anesthesia consumers tend to seek a sense of reality in ever stronger sensations. They tend to seek meaning for their lives and power over others by enduring undiagnosable pains and unrelievable anxieties: the hectic life of business executives, the self-punishment of the rat-race, and the intense exposure to violence and sadism in films and on television. In such a society the advocacy of a renewed style in the art of suffering that incorporates the competent use of new techniques will inevitably be misinterpreted as a sick desire for pain: as obscurantism, romanticism, dolorism, or sadism. pp. 152-153

The sufferings for which traditional cultures have evolved endurance sometimes generated unbearable anguish, tortured imprecations, and maddening blasphemies; they were also self-limiting. The new experience that has replaced dignified suffering is artificially prolonged, opaque, depersonalized maintenance. Increasingly, pain-killing turns people into unfeeling spectators of their own decaying selves. p. 154

The age of hospital medicine, which from rise to fall lasted no more than a century and a half, is coming to an end. Clinical measurement has been diffused throughout society. Society has become a clinic, and all citizens have become patients whose blood pressure is constantly being watched and regulated to fall "within" normal limits. The acute problems of manpower, money, access, and control that beset hospitals everywhere can be interpreted as symptoms of a new crisis in the concept of disease. This is a true crisis because it admits of two opposing solutions, both of which make present hospitals obsolete. The first solution is a further sickening medicalization of health care, expanding still further the clinical control of the medical profession over the ambulatory population. The second is a critical, scientifically sound demedicalization of the concept of disease. pp. 165-166

An advanced industrial society is sick-making because it disables people from coping with their environment and, when they break down, from substituting a “clinical” prosthesis for the broken relationships. People would rebel against such an environment if medicine did not explain their biological disorientation as a defect in their health, rather than as defect in the way of life which is imposed on them or which they impose on themselves. p. 169

The physician, himself a member of the dominating class, judges that the individual does not fit into an environment that has been engineered and is administered by other professionals, instead of accusing his colleagues of creating environments into which the human organism cannot fit. p. 169

4. The Politics of Health

The aged are an example of the specialization of poverty which the overspecialization of services can bring forth. The elderly in the United States are only one extreme example of suffering promoted by high-cost deprivation. Having learned to consider old age akin to disease, they have developed unlimited economic needs in order to pay for interminable therapies, which are usually ineffective, are frequently demeaning and painful, and call more often than not for reclusion in a special milieu. p. 219

The World Health Organization, meanwhile, is moving to a conclusion that would have shocked most of its founders: in a recent publication WHO advocates the deprofessionalization of primary care as the most important single step in raising national health levels. p. 227

The person who, upon the diagnosis of cancer, chooses an operation over a binge in the Bahamas does not know what effect his choice will have on his remaining time of grace. The economics of health is a curious discipline, somewhat reminiscent of the theology of indulgences which flourished before Luther. You can count what the friars collect, you can look at the temples they build, you can take part in the liturgies they indulge in, but you can only guess what the traffic in remission from purgatory does to the soul after death. Models developed to account for the willingness of taxpayers to foot rising medical bills constitute similar scholastic guesswork about the new world-spanning church of medicine. pp. 231-233

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

not mean that their services shall not be evaluated, but rather that this evaluation can be done more effectively by informed clients than by their own peers. . . .

Deprofessionalization of medicine means the unmasking of the myth according to which technical progress demands the solution of human problems by the application of scientific principles, the myth of benefit through an increase in the specialization of labor, through multiplication of arcane manipulations, and the myth that increasing dependence of people on the right of access to impersonal institutions is better than trust in one another. pp. 255-256

Better health care will depend, not on some new therapeutic standard, but on the level of willingness and competence to engage in self-care. p. 270

Increasing and irreparable damage accompanies present industrial expansion in all sectors. In medicine this damage appears as iatrogenesis. Iatrogenesis is clinical when pain, sickness, and death result from medical care; it is social when health policies reinforce an industrial organization that generates ill-health; it is cultural and symbolic when medically sponsored behavior and delusions restrict the vital autonomy of people by undermining their competence in growing up, caring for each other, and aging, or when medical intervention cripples personal responses to pain, disability, impairment, anguish, and death. 270-271

Health is a task, and as such is not comparable to the physiological balance of beasts. Success in this personal task is in large part the result of the self-awareness, self-discipline, and inner resources by which each person regulates his own daily rhythm and actions, his diet, and his sexual activity. Knowledge encompassing desirable activities, competent performance, the commitment to enhance health in others - these are all learned from the example of peers or elders. These personal activities are shaped and conditioned by the culture in which the individual grows up. pp 273-274