

Institutionalization and Medical Viewpoints in Industrial Societies. An Historical Introduction

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The following contributions were originally produced for the International Seminar on the Study of Occupational Health Systems and the Professions of the Welfare State, held at the University of Bergen on 2nd and 3rd September 1991, where 33 participants from Bergen, Oslo, Troms, Linköping and Bremen met at the invitation of the Occupational Health and Professions Seminar SEFOS. The constellation of participants ensured a fruitful discussion on the interdisciplinary aspects of the theme and especially the historical and international. When dealing with questions of risk, insurance or welfare society, these aspects should be taken into account in every academic discourse.

During the conference the question of work-related health risks and the responsibilities of a socially understood medicine was approached from the point of view of professionalisation in the course of modern societal development. At the same time, there was a stimulating exchange of views between historical sociology and current theories of political and social science. Fresh interest was shown in the comparison between German and Scandinavian experiences due to the international discussions and exchange of information and also to the examination of specific sociopolitical developments. Norwegian doctors, for instance, were particularly interested in the discussions between the medical profession and the health insurance companies on the question of being free to choose one's own doctor in Germany at the turn of this century. On the other hand, the highly

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DYNAMIS

Acta Hispanica ad Medicinæ Scientiarumque Historiam Illustrandam. Vol. 13, 1993, pp. 19-28.
ISSN: 0211-9536

complex and dynamic process of professionalisation was in many ways dependent on the institutions which expanded as national welfare states developed (see J. Alber, 1982).

One important outcome of the lively discussions can be worded to the effect that neither health problems nor the activities of the medical profession can be successfully analysed in isolation from one another. Whether a health problem was identified as such or not has in industrialised countries, since the second half of the 19th century at the latest, depended on medical definitions. And the exemplary professionalisation of doctors cannot be fully explained without taking into account the pressures of contemporary social problems (see D. Milles, 1989 and 1990). But how can this connection be described in theoretical terms?

First of all, the single components of the correlation must be determined. One important link between the pressures of social problems and professionalisation appears to lie in a point of view which found general social acceptance, that is the assessment of health risks on the basis of determinable physical impairments and the establishment of threshold values for health risks (see D. Milles, 1988). This positivistic point of view shaped the articulation of health risks and defined which risks were normal and which exceptional, which were acceptable and which should be reduced. At the same time it formed the framework within which medical knowledge assumed social responsibilities in the diagnosis and assessment of certain diseases. In particular, this point of view became more dominant because it only recognised sociopolitically relevant actions on the basis of identifiable and verifiable conditions. It thus adopted important aspects of liberal ideology which subjected the justification for state or societal action to strict preconditions, but bound them at the same time to the requirements of an interventionist state which was increasingly forced to produce and maintain social conditions. Medical assessments advanced to become the paragon of socio-political expertise and medical experts an example of successful professionalisation (see G. Göckenjan, 1985).

During the discussions in Bergen it also became apparent that the positivistic medical view was the specific product of welfare state developments the characteristics of which varied from one country to the next, but which can all be understood as social security institutions. It was only within this framework that the professional roles of doctors, certain medical knowledge and professional standards of examination and assessment were able to take shape.

These points of interest and the results of the discussions in Bergen coincide with a recent growing interest in the history of institutions. The institutional development of industrial societies also appears to be of central importance for the history of medical viewpoints and medical professionalisation.

One may ask whether a history of state structures is sufficient to understand the welfare state institutions which all have different or very general objectives. Whilst social and political scientists increasingly tend to reflect on the historical dimensions, one must concur with P. Baldwin that in general historians still do not have a fully developed definition of the term «welfare state» (P. Baldwin, 1990, p. 1). Baldwin himself discusses the interests and ambitions of certain groups, and especially the workers movement, in terms of causal motives for political action. This «social-democratic interpretation of the welfare state», which arose out of the post-war reform movement, neither corresponds with the historical origins of social reform nor with the ambitions of reformers. Baldwin finally asks whether it really was classes, occupational groups or other interest groups which were the historical actors. He concludes that the social insurance system, among others, created and defined its own actors. Beyond the classification of class and social strata, Baldwin suggests the application of the terms «risk community» or «risk categories» for groups with similar interests in relation to the social insurance system. «The struggles for social insurance reform have in general taken place between different risk categories, between those who hoped to gain and those who feared to lose.» Baldwin thus calls for a revision of our conception of historical actors in this respect (P. Baldwin, 1990). Here he addresses a political and social reality which was created by sociopolitical institutions and then took on a momentum of its own, and has only begun to be discussed in political and historical research, but not yet examined in relation to industrial diseases and occupational health care.

The question of historical actors and their actions is also essentially concerned with «social medicine», i.e. functions which do not derive from the direct, individual relationship between doctor and patient. Does historically relevant action arise out of an aggregate of individual needs or problems, or does a socio-political factor have to be assumed, with which overriding objectives are brought to bear on individual actions?

Up until now the question of historical conceptions of «social medicine» has (in Germany) mainly been approached from the angle of the history of definitions (see E. Lesky, 1977). Only a few studies have looked

at socio-historical connections (Michael Hubenstorf has taken up this approach in his dissertation which will be published shortly; a recent work modelled on old concepts is S. Hahn; A. Thom, 1991). Strictly speaking, the endeavour is still being made, as with the epidemic paradigm, to determine the historical and sociopolitical quality in the diseases themselves. Mediating between conceptual history and social history are studies which do not refer to the real sociopolitical content of health or illness, but to the sociopolitical content of the medical definition of health and illness. More recent discussions are profiting more and more from impulses arising out of discussions between various disciplines. Here, conceptual questions are necessarily the initial focal point of attention.

The medico-sociological understanding of health and disease has extended to integrate these concepts into institutions and the constructions of normality. Cultural, political or economic influences on the perception, definition and treatment of diseases are weighted and reappear in the conceptualisation of how diseases arise and develop. In a condensed historical and systematic form, these concepts can be categorised as the structural-functionalistic paradigm («illness as social role and motivated deviance»), the interactionistic paradigm («illness as professional construction»), the phenomenological paradigm («illness as intersubjectively constructed reality») and the conflict theory paradigm («illness as failure of resources and ideological construct») (U. Gerhardt, 1989). Accordingly, the necessary sociological analysis of disease processes must be carried out as an analysis of the historical and social conditions surrounding their conceptualisation. This genuinely sociological approach was not, however, applied systematically to the subject matter of the Bergen Conference.

Results of the study of the social history of medicine, which has now become a well-established discipline (A. Labisch; R. Spree, 1989), have underlined that in the analysis of professionalisation or of problems related to medical actions methodological difficulties can arise if medical definitions are applied to analyse the actions of the medical profession. Alfons Labisch has recently traced the line of development of the medical point of view of health hazards and the combat of diseases in civil society (A. Labisch, 1992), and points out the remarkable fact that certain terms, for instance «health service reform», are interpreted in rapid succession either as the extension and better distribution or, alternatively, the restriction and concentration of medical services. He enquires further into the contrast between the exposure of medicine «as a subtle instrument of social power»

(*ibidem*, p. 7) and the increasing demand for medical assistance which in turn is criticised as «demand inflation». Public attitudes to health and medicine can neither today nor in the past be understood in terms of health problems per se or specific medical skills or capabilities alone. A. Labisch thus comprehends health and medicine as a problem of social relations, and he describes the process by which the scientific interpretation of health, which had initially arisen as a maxim of the middle class, became a general and binding social construct. This construct provided various organisational forms of social security in the civilised world with a common goal.

The conceptual and terminological integration of the — ostensibly — scientifically derived medical modes of argumentation and behaviour into the social construction of reality has been convincingly demonstrated with interdisciplinary surveys which attempt to overcome the separation between illness and social reality (J. Lachmund; G. Stollberg, 1992). Thus, the scope of social history is broadened to no longer only mean the addition of social factors to the history of diseases, hospitals, doctors or fields of specialisation, but also the social reconstruction of interactions, in which illness itself is a social phenomenon. The question is then: «how are bodily processes experienced as a problem, and how are they rendered socially significant? How is the body perceived as an entity? How do people cope with illness?» (*l.c.*, p. 9) If, however, it is asserted from a constructionist perspective: «all of these are based on culturally entrenched structures of sensibility, body images, illness vocabularies, and related symbolic practices (*ibidem*), then the historical explanation is substituted by the construction. One then has to examine the principles of construction and, especially, who the constructors were. If, in reply to this, reference is not to be made back to the dominance of medical points of view and definitions, then other historical answers must be sought.

There has been an inevitable social involvement of medical definitions and medical actions in historical reality since the beginnings of the social insurance system at the end of the 19th century. The social insurance institution seems to have left such a strong impression on historical developments that through it actors and concepts, points of view and intersubjective aims in the context of work and health since the last quarter of the 19th century can be studied.

International comparative studies often emphasize the exemplary significance of German workmen's insurance. «The German program represents

a critical point in the development of the disability category, not only because it became a model, explicitly or implicitly, for all subsequent social insurance programs. There is ample evidence that policymakers from several countries consciously examined the German system during the phase of study and legislative drafting in their own countries» (D. A. Stone, 1984, p. 56). The lines of development of at least three types of welfare state were the subject of interest at the conference, in particular in the light of the coming sociopolitical integration of West Europe. The different sociopolitical regimes are categorised as the Scandinavian, the Bismarckian and the Anglo-Saxon types or «worlds of welfare capitalism» (D. Esping-Andersen, 1990; see the general survey in S. Leibfried, 1990). In this broad discussion, however, it is the poverty paradigm which is focussed on as a model — even for health insurance — and not the accident paradigm as a model for risk management. Yet the «compensation strategy», which was emphasized in the German development, takes a well-functioning risk management, organised within the framework of accident insurance, for granted. One fundamental research hypothesis could be that the very combination of medical viewpoints and the crisis management of an insurance society explains the triumph of medicine based on clinical assessment as a particular variant of social medicine.

The historical professionalisation of doctors in the context of industrial and welfare state development was discussed in Bergen along these lines as, essentially, a form of institutionalisation.

While the processes of professionalisation have for quite some time been the object of remarkable academic interest, institutionalisation processes have, in a specific academic tradition, been neglected. This must urgently be remedied.

The processes of institutionalisation were first examined from a sociopolitical point of view. In this book, political institutions are understood as «regulating systems for the production and execution of generally binding decisions» (G. Köhler *et al.*, 1990, p. 12). A regulative social function of institutions is thus assumed, which in turn is of primary significance for the history of social medicine.

For the history of health risks and medical viewpoints, the institutionally organised relationship between a certain measure of effective power, the setting of legal norms and acceptance by the persons affected is of particular relevance.

However, a certain amount of caution is advised towards a too simple historiography. If, for instance, the objective is to determine the functional equivalent for political institutions as they are understood today, in the historical concepts and lines of reasoning (*ibidem*, p. 13), then the historical analysis is reduced to a portrayal of the forerunners of today's institutions. This type of history of ideas which does not allow any further academic verification or correction, but is simply seeking to identify «modern» approaches, really only delivers a confirmation of the definition of institutions as it is applied today.

An alternative to this approach was developed some time ago in Bremen and Kassel which involved the search for «buried alternatives». This perhaps misleading term means moving away from linear historical models of explanation and maintaining a critical position towards historical experience. Historical knowledge thus still remains discursive and is not permitted to atrophy to a means of justification or illustration. For this reason objects of study, such as the dispensaries of the General Health Insurance Company during the Weimar Republic (see E. Hansen *et al.*, 1981), were selected for research, as they indicate the direction which subsequent debates would take and do not portray the «making» of history from the point of view of the triumphant actors.

The term «buried alternatives» also involves two problematical aspects insofar as it suggests that certain historical positions should be analysed relatively independent of each other and accorded equal status, and that these alternatives only have to be recollected for them to reappear from more or less unintended isolation. For this reason, in Bremen, great importance has always been attached to understanding history as a perpetual discussion and historical analysis as part of this discussion. Attention has therefore been paid to historical-comparative questions and methods.

These considerations appear to be very profitable for the historical analysis of welfare state institutions and medical conceptions. What essentially is needed is a social analysis based on the principle that «history is not illogical, but its logic is not mechanical» (J. A. Schülein, 1987, p. 19). For developing a concept of institutionalisation and the significance of institutions in history, the following important assumptions of their basic development have therefore always been effective:

- the optimistic assumption of a progressive tendency with increasingly improving conditions for general well-being; or

— the pessimistic assumption of egotistical power interests which have to be restrained by state intervention.

Today, there is some agreement that the tendencies of institution theories to undefined generality and socio-biological inferences which have dominated up until now must be countered with a relational version. «Institutions are not isolable units, but represent a relationship» (*Ibidem*, p. 131). Such primary and secondary relations can be differentiated according to ecological or teleological motives, depending on whether basic needs or specific objectives are concerned.

This discussion appears to be crucial for progressing in the understanding of strategies and actions in social medicine and health policy. The role of the idea of prevention, which is central to the history of occupational diseases and occupational health care, has been examined with respect to the history of public health care and social medicine taking both the ecological and the teleological perspectives into account (D. Milles, 1991). The justifications for public health go beyond individuals and the treatment of their own bodies and assume a general interest to which the individual is committed with body and soul. The difficulty of this assumption, i.e. that prevention is fundamentally a political issue and cannot be determined with exact methods, underlines the importance of the historical analysis of discourse for establishing whether preventive needs, demands, strategies or programmes are fundamentally anthropological in nature (for instance in the assumption of equality in the solidary communities of social insurance) or based on specific objectives (for instance the provision of sufficient medical care). The really important task for historians is then to establish what the justifications were for the adoption of prevention strategies and how effective they were (see A. Windhoff-Héritier, 1989).

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