

On the history of medicine in the United States, theory, health insurance, and psychiatry: an interview with Charles Rosenberg

Sobre a história da medicina nos EUA, teoria, seguro-saúde e psiquiatria: uma entrevista com Charles Rosenberg

Interview with:

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Given to

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Abstract

An interview with Charles Rosenberg conducted by Rafael Mantovani in November 2013 that addressed four topics. It first focused on the way in which Rosenberg perceived trends and directions in historical research on medicine in the United States during the second half of the twentieth century. The second focus was on his experience with other important historians who wrote about public health. Thirdly, he discussed his impressions about the current debate on health policy in his country. Finally, the last part explores some themes related to psychiatry and behavior control that have appeared in a number of his articles.

Keywords: Charles Rosenberg (1936-); history of medicine; United States of America; theory; Obamacare.

Resumo

Foram analisados quatro tópicos em uma entrevista com Charles Rosenberg conduzida por Rafael Mantovani, em novembro de 2013. Primeiramente, Rosenberg apresentou sua visão sobre as novas tendências e direções em pesquisas históricas sobre medicina nos EUA na segunda metade do século XX. Em seguida, falou sobre sua experiência com outros renomados historiadores que escreveram sobre saúde pública. O terceiro tópico girou em torno de suas impressões sobre o debate atual acerca da política de saúde em seu país. Por último, foram explorados alguns temas relacionados à psiquiatria e ao controle comportamental, presentes em diversos de seus artigos.

Palavras-chave: Charles Rosenberg (1936-); história da medicina; EUA; teoria; Obamacare.

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Charles Rosenberg, professor of the history of science, and Ernest Monrad, professor of the social sciences at Harvard University, has had a profound influence on generations of historians of science and medicine in the United States and abroad. His landmark book – edited with Janet Lynne Golden in 1992 entitled *Framing disease: studies in cultural history* – explains the relationship between medicine and culture. In summary, according to the book, societies frame diseases, but diseases also frame people (Rosenberg, Golden, 1992). Moreover, from Rosenberg’s perspective, disease is an important “actor” in society, an actor who provides scripts for negotiation among the sick, health insurance plans, government, clinicians and biomedical researchers (Rosenberg, Golden, 1992; Rosenberg, 1992, p.314).

When I suggested this interview to Rosenberg, I was interested in hearing to him talk about the history of medicine in America and about theoretical frameworks that might be instrumental to research in the field. As my research interests focus on public health, I decided to include questions about medical historians who worked on this subject, authors who discussed public health in a political context.

His perspective on the links between history and contemporary medical and public health issues is relevant because of his training. As an undergraduate, Rosenberg studied with Erwin H. Ackerknecht (1906-1988) at the University of Wisconsin in the fifties and, with him, Rosenberg realized that the way an individual understands disease not only related to its clinical manifestations, but also to the needs of his culture (Rosenberg, 1987a, p.235). Charles Rosenberg was also influenced by George Rosen, who studied the role of the state in medicine. Both Ackerknecht and Rosen were medically trained, left-oriented historians and both were influential among scholars concerned with the development of health and health policy.

The questions on theoretical frameworks in this interview were inspired by the 1987 second, expanded edition of Rosenberg’s *The cholera years: the United States in 1832, 1849, and 1866* (his first book, originally published in 1962, based on his doctoral thesis defended at Columbia University), that included a rich afterword about theory and his reflections on a text published 25 years earlier.

The first part of our interview focused on this question: how does Rosenberg perceive the major trends in the past half-century of scholarship in the history of medicine.

To talk about US public health in 2013 without mentioning the intense debates generated by the set of reforms that President Obama had been attempting to implement would mean ignoring today’s most prominent and intense health policy debate. So I wanted to know what the role of historians should be in this debate. He noted that the discussion is dominated by economists and political scientists, but historians could play a more active role. According to Rosenberg, there is, for example, important moral energy in this debate, one with fundamental roots in the past as well as the more obvious intellectual and institutional factors that shape contemporary policy choices.

Finally, I wanted to know if he had had some additional reflections regarding the branch of medicine that deals with anxiety and “behavioral maladjustments:” psychiatry. In some chapters in the 1992 publication *Explaining epidemics and other studies in the history of medicine*, Rosenberg (p.245-257) discusses the scientific basis, legitimacy, and efficacy of psychiatry. In his most recent book, *Our present complaint: American medicine, then and now*, released in 2007, he discusses the agreements between social groups on the moving frontiers that define

what mental disease is and is not – and, more generally, the development of modern concepts of disease specificity (Rosenberg, 2007b, p.38-59). In an interview recently published in *Biosocieties*, he discussed the implications of the 5th Diagnostic and Statistical Manual of Mental Disorders (DSM-5) – the standard classification of mental disorders used by mental health professionals in the United States – and his opinion appears in the last part of this interview.

Rosenberg is a very important figure in the history of medicine, in Brazil and internationally. His insights have helped us understand the social dimension of getting ill, diagnosis and cure. In this interview, published in *História, Ciências, Saúde – Manguinhos*, he offers reflections and considerations on the history of medicine and public health.



Could you talk about the changes in social attitudes in the fifties and sixties that influenced your life and training?

I think there was a growing critical mood – in Europe as well as in the United States – critical for some in the Marxist sense, but more frequently in a diffuse sense, asking questions about authority and the basis for its legitimacy. In other words, the professional establishment was questioned, whether the establishment was doctors, lawyers, or politicians. Obviously, this spirit of questioning became more prevalent and intense in the sixties. I think this willingness to question authority was directed at a variety of issues – ideas and practices relating to race, gender, political institutions and class. Race and gender were more foregrounded in the United States. But there was a general skepticism toward positivist models of truth, which anti-authoritarian critics regarded as necessarily hierarchical, because they assumed that people with certain kinds of credentialed training have an authority inherent in that training, in possessing analytical abilities that ordinary people lacked. So, in that sense, the positivist view seemed very conservative or, at least, that was what a lot of people in the sixties and seventies thought. And in this country, a good many young men and women reflected and internalized an eclectic combination of the civil rights' movement, woman's movement, and a bit of environmental criticism. Subsequently, the Vietnam War came and a more general post-colonial critique made everything more intense.

In The cholera years' afterword of 1987 you mention the effect of Gramsci and Foucault in the United States.

This was all underway before Foucault was translated in the United States. Gramsci was not really well known in this country until the late seventies and eighties. Only people interested in theory, who were in fact a small minority. I think there was a lot of diffuse and derivative Marxism; in other words, some people in the sixties and early seventies were influenced by a kind of Marxist style of rhetoric, but the great majority of such critics were not systematically trained: some might cite Gramsci, for example, but not necessarily have read him. It is the same about Foucault, of course. Something similar happened later with Derrida. This whole genealogy of critics was dismissive of what you might call the positivist establishment. It happened gradually. If you lived through it, like many other intellectual trends that seem clear in retrospect, it just sort of happens in a pervasive and multi-dimensional way. Such

changes of attitude and assumption are generational, of course. Many in the establishment today, the senior professors and politicians, are people who were young in the sixties and seventies. So we have a new configuration of attitudes in the academy about authority in science, in medicine, in policy making generally. Not to mention cultural issues like gay marriage, abortion, and woman's rights. Such concerns are not unrelated. And attitudes on the right as well as the left have roots in this earlier generation.

You wrote that prudence dictated that one should study and write about seemingly unambiguous data in the early sixties. Do you think that today there are still studies which present themselves as atheoretical?

That is an interesting question. We have a lot of people who invoke theory, but there are lots of different theories. It is hard to say that there is one orthodoxy. For example, there are historians and social scientists who are very interested in questions of global economics relationships and who see economic development, colonialism, slavery, trade patterns, development of certain crops and commodities as key issues. You cannot understand one country without understanding its relationship with world trade, world population movements etc. You might say some studies were influenced very much by postcolonial theory, by Marxist writings, but this influence wasn't and isn't systematic. It is not an invocation of specific texts, of philosophical formulations. It is much more how they choose their subjects. It is as much moral criticism, in terms of motivation and orientation, as it is a response to systematic philosophical formulations. At least that seems to me true of history, the field I know best. There was a lot of interest in language, what is called post-structural interpretations of society. Language and public performance become the key to understanding particular societies in particular times and places; words and performance become everything. So, there are a variety of scholars who will talk about "performing who you are," arguing that you learn certain roles, you learn certain attitudes, and one acts out these cultural norms, cultural values and cultural practices without their being understood as contingent and constructed. But they nevertheless constrain you and form you.

But there are different versions of that kind of larger cultural viewpoint and I guess you can trace them back to a variety of inter-war scholars and social critics, to a whole series of left sociological and ethno-historical traditions with a lot of bumps along the way. To me the most striking thing is how eclectic this situation is today, eclectic in the sense that there seem to be no rigid schools of history. You have that kind of formal approach probably only in areas like economic history and demography, where quantitative methods and formal hypotheses dominate, and where there has been less attention paid to softer – institutional and historical, less easily modeled – factors. Among historians, it is not as popular as it is among economists, and I think economists are getting more and more critical about that formal and abstracted orientation. Years ago, back in the sixties, there was a school of historians who were very explicitly positivist, "scientific," who would want to do only things with data collected systematically: voting records, demographic records, imports and exports etc. Even though it was very aggressive for a while, this positivist quantifying and model-building style never came to dominate the writing of history in the United States. Another area of increasing interest among historians is what one might call material history, especially questions relating

to the physical environment. I think much of the interest in environmental history has grown out of a critical interest in trade and economic relationships. A more recent interest in climate change has only intensified such interests; it is an interest obviously consistent with a concern for the history of agriculture and trade, of colonies and commodities. The history of energy, for example, has become an exciting – one hesitates to say hot – field. All of these concerns, I believe, reflect an underlying concern with the moral trajectory of mankind: where are we going? How can history help us understand that trajectory? We cannot divorce ourselves as a species and as scholars from the material world.

What are the most exciting questions in history nowadays?

As I have just suggested, I think environmental issues are one. Another, which is obviously related, would be the global approach: Atlantic history, Mediterranean history etc. These are not entirely novel foci, but they are increasingly influential as they question the model of the nation as the proper unit of study. It makes the understanding of social and spatial relationships more fluid, relationships that involve movement of people, movement of commodities etc. And in the contemporary world, I think young people are fascinated by those kinds of questions. I would think that, in Brazil, the environment would be very important. And also global history, commodities and slave and free labor. Brazil is very rich in commodities. All that oil and water and agricultural land! You could not really understand Brazilian history without understanding the way, on the one hand, government bureaucracy thinks about itself or the Brazilian ideas about the world of trade and commodities. It also reflects climate, environment, in the sense of “what is there.” If there were a desert inland from the ocean, wouldn't it be a different country? So the question is: how does that fit within the world and create particular choices for the Brazilian government – and the Brazilian business community?

How do you perceive the influence of inter-war German thought and socialist thought in the United States' history of medicine? Sigerist, Rosen, Ackerknecht...

Sigerist was a little older, he was certainly a socialist in what I would describe as a sort of European soft socialist tradition. If there is a place where humanism and socialism meet, that would be Sigerist. If you want a label that would describe those influential refugee scholars you mentioned, I would say that they all represented what one might call the “social medicine tradition,” a tradition in which you look at medicine as a social function, you see medical theory, the practice of medicine, and accessibility to medical care by ordinary people as an outcome of social conditions, social values, and social criticism. Their hero was someone like Rudolf Virchow. Their main argument was that when you think of disease, you have to think of it as the aggregate outcome of social arrangements and social circumstances. According to this perspective, you cannot take medicine away from society. Issues like exploitation of labor or crowding and density of population in the city cause tuberculosis, cause infant mortality. You cannot just blame it on a germ. You cannot just isolate that germ in a microscope and say you have solved the problem. We still study infant mortality as an indicator of general social conditions, and we see differences from one place to another even within the same city, the same country in terms of issues like life expectancy. But infant mortality is a quick

and easy indicator. So I think that the tradition of seeing medicine as an outcome of the aggregate of social realities, social exploitation, social “progress” was a key to all these people; even though their specific politics were different (Ackerknecht, for example, was a Trotskyist as a young man and ended up as a kind of disillusioned right-winger late in life).¹ All of those generations had in common the instinct, the intuition, a reflexive way of seeing medicine as embedded in society and society embedded in medicine. It meant that epidemiology has always been a social science.

What should be the role of historians in the debates on Obamacare?

That is tricky, of course, because the public debate surrounding health policy has been dominated more by economists and political scientists than by historians. So the debate has been much more organizational than historical. But many of the people who do policy stuff have some interest in history, because you cannot understand this contemporary debate about health insurance or access to healthcare without understanding the long history of attempts to create a national health system. Anyway, we seem to be stuck at the moment with our irrationally complex system with a little piece here, a little piece there, another one over there... It makes American health policy very historical in the sense of representing a set of compromises, a set of power relationships, and a set of accidental circumstances. You put them all together over time and you get this crazy healthcare system. Only history could explain it! But I do not think that historians are playing a very active role in educating the public. I think we could do better.

How?

I think maybe writing for newspapers, being more visible. But it is very hard. Some of the ideological and political positions are so forceful and widely disseminated in the public that it is very hard to change fixed ideas. In addition, most Americans do not have any sense of where the American system fits in with the rest of the world. If you told most Americans that life expectancy in Cuba is roughly the same as that in the United States, they would not believe you. The average American somehow associates hi-tech with better medicine, and so they assume that the country that has access to the most elaborate technology has the best outcomes. Politicians say that all the time. A lot of stakeholders – whether they are manufacturing PET scans [magnetic resonance images], IV units [intravenous therapy equipment], whether they are doctors, specialists, insurance companies or pharmaceutical companies – they all are generally happy with or at least tolerate things the way they are. Because healthcare in the United States has been pretty much cost-plus, in the sense that there is no national budget. We have not had a limit on how much we can spend in the course of a year. We spend based on procedures and on visits and there is always somebody making a profit with no consistent central regulation. Unfortunately, most Americans are not aware that this situation is not typical of other economically developed countries. Unless they are very involved in politics, and most Americans are not.

¹ About Ackerknecht, see Rosenberg (2007a).

So what do you think about Obamacare?

I think it is brilliant that the republicans got to call it “Obamacare.” It moves the debate forward in a political, personalized way, and it obscures the economic and moral logic behind health reform: it is not right that poor and middle-class people might become bankrupt because they get sick, it is not right for some people to receive much better care than others. This is a moral argument (though it is not always or consistently presented as such), but it also has an economic aspect. We have maybe forty million uninsured people, and to say “just go to an emergency room” is not an answer to their inevitable needs. I think there is a moral energy behind it, as I have said, but there is also a practical economical argument that in the long run you have to control costs. (The actual bill is, in fact, called “the affordable care act.”) I believe that one can control costs and still have first-rate care available for the great majority of the population and some experts believe that the health insurance of most working-age Americans – insurance through their employers – remains viable and thus limits the support for universal, portable health insurance of some sort. But as companies are getting more and more cost-conscious, they are cutting back on healthcare. So even if they provide it, it is often less than adequate. Some employers, especially in retail and services, provide minimal coverage – and in some cases none at all. So, continuing as we are is not a viable situation, neither morally nor economically.

Obama initially thought that his health reform program would be an effective and politically viable policy, but the legislation itself is quite complicated because the President’s coalition did not want to antagonize too many powerful interests and individuals. The result was to build healthcare legislation around the existing insurance structure. In any case, it does have some very positive components; one is that it does provide an accessible form of basic insurance that low-income people can purchase with a subsidy. A second positive component is that it is portable in the sense that, if you have a job you hate and want to quit or if you want to get divorced and move to another state or city, you will still have access to health insurance. Another provision in the legislation – there are lots of parts – is that it builds in minimal standards. You cannot, for example, be turned down because of a preexisting condition. It also mandates that certain preventive measures be covered, such as pre-natal care. Much previous health insurance available to individuals was simply inadequate in its coverage. If the insured person came down with cancer, the insurer might say “if you had cancer when you signed that insurance agreement we will not pay for it.” Some policies sold previously included a specified lifetime reimbursement limit: “we will only pay up to US\$100,000, no matter what.” There are many conditions that can easily cost a million dollars to treat. The legislation also says that children can stay on their parents’ insurance until they are 26. Before it was 21. States have their own standards for health insurance, so it gets very complicated, and I am far from an expert. I think that the problem is that a lot of people are perfectly happy with their own insurance, because they have a stable employer. But the quality and comprehensiveness of employer-provided insurance is under threat, partially because the pressures on corporations to cut costs are increasing and many companies fire older workers, then hire younger ones and give them inferior benefits.

Is American society pushing the responsibility for health onto individuals? What might create a bigger health obsession in American society than that existing a few decades ago?

I do not know what the metric is for measuring health-related anxieties. Maybe it is worse now, but also people have more leisure time and more sense of choice. In the nineteenth century, most people could not go to the gym and exercise because they were busy working 12 hours a day, six days a week. Neither did they have a choice in the food they ate, there was little that ordinarily people could afford, so they did not worry if it was organic or well balanced. We have more space to impose these new anxieties, because we have more choices.

Talking about anxiety, in 1992 you questioned the justification for mandatory medical training of psychiatrists. But even if there are doubts about the scientific/medical approach to psychiatry, it does not seem to be an issue since, as you say in the 2013 Biosocieties interview, nobody thinks that DSM categories really exist other than as bureaucratic or research classifications, even though the manuals are getting bigger and we treat these categories as things, as “mechanical processes.”

I do not recall having written explicitly about medical training for psychiatrists – but otherwise I do not think that my ideas about psychiatric diagnosis have changed that much since the early 1990s. You could argue that the DSM gets bigger and is used so widely because it makes the system work within this bureaucratic world we live in. You have to have names for things. It makes the system function. I know it sounds terrible, but in a way, people are in some dimension not individuals, they are categories; even if at the same time they are individual women and men. To legitimate the world of medicine as a reassuring and socially legitimate actor in society, psychiatry has to be able to provide answers, labels, and protocols. There are lots of psychiatrists arguing that they do not really take the DSM seriously in terms of an individual patient or the firm and discrete existence of the “disease” they have diagnosed them with. But if pressed they would probably say: “but we need it anyway, because of a whole set of reasons. One is: how do you compare research from one place to another? How can you have a baseline of therapeutic practice which says ‘this is the established, plausible, acceptable ways of treating somebody?’” You have to have some consensus to make the social system work. Otherwise, some people would go to church and light a candle, some people would smoke marijuana, or undertake extreme physical exercises. A cynic might say these practices would work as well as psychiatry, but what I am saying is that this whole area is ambiguous and filled with emotion and guilt... And also lack of understanding. The reason why the DSM works as a descriptive thing is because it says “we do not know what the cause is, we are just going to say that if an individual exhibits certain behaviors we will agree to label that behavior a certain way.” Does that agreement explain the mechanism underlying the behavior or specify a treatment? What does it mean that practitioners can often agree to describe a behavioral or emotional pattern using the same language and set of – perhaps arbitrary – categories? It is not irrelevant. It may help in terms of giving you some sense of the likely trajectory of the painful or difficult behavior. It gives you a working framework with which to look at individual patients. This is a kind of sociological way of thinking about how doctors manage indeterminacy because, especially in psychiatric illnesses – but also with a lot of cancers or other unambiguously organic ills – you do not know what is going to happen.

Are psychiatrists the spokesmen of a new holistic approach in allopathic medicine since they consider age, gender and cultural perspectives? Is it the tyranny of diagnosis under a new holistic approach?

Psychiatry has always dealt with the edge of medicine, where one can ask: what is disease and what is emotional pain? What is depression? Is it a pathology or group of pathologies? Are they “diseases” or aspects of the human condition? Are certain extreme manifestations of such feelings diseases? And if they are, how do we agree on distinguishing and defining them? I have tried to address this question a number of times in the past: psychiatry is always dealing with the boundary issues surrounding human deviance, pain, and behavioral maladjustment. I often remind students that there are certain diseases that used to be psychiatric, like pellagra or tertiary syphilis. Once it was discovered that pellagra was a dietary deficiency disease, it was taken away from psychiatry. Syphilis provides a parallel case. In 1910, a substantial number of patients in mental hospitals were deteriorated syphilitics and the unfortunate hospital psychiatrists were responsible for them. But after penicillin, it could be a medical, treatable, preventable disease. Psychiatry has always been responsible for the elusive and never-ending pain that human beings suffer and inflict. We will never run out of bad marriages, depression, and socially-defined deviance of one sort or another.

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