Commentary: From sick men and women, to patients, and thence to clients and consumers—the structuring of the ‘patient’ in the modern world

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The juxtaposition of the word cosmology with medicine might appear as somewhat discordant to medically trained professionals. It is an odd word; suggestive as it is of a theory of everything. Not surprisingly, perhaps, Jewson goes to considerable lengths to define the term in his opening paragraphs. Thus, cosmologies are referred to as conceptual structures; as metaphysical attempts to define the nature of medical discourse; as intellectual frames in terms of which people make sense of their worlds; as ways of knowing; and things that function as a medium within and through which perceptions of self and other are expressed, and institutionalized. They might be regarded, suggests Jewson, as akin to Foucault’s notion of a ‘discursive formation’.

Suffice to say that the language and preliminary content of Jewson’s 1976 paper inevitably reflect the concerns of the age. Thus, the reference to cosmology, in particular, is characteristic of a sociology that was closely focused on the content and role of belief systems (religious and secular) and the place of ideology in social and economic affairs. Equally, characteristic of the age are Jewson’s use of Marxist terminology—especially his deployment of the concept of the ‘mode of production’. In that respect Jewson’s work stands at a juncture where an interest in the content of ‘belief’ was developing into a concern with the ways in which knowledge, including scientific and medical knowledge, was produced rather than ‘discovered’; and the ways in which positions (such as those of patient and doctor) were reproduced in and through everyday social practices. Above all, by drawing upon the resources of classical Marxist theory, Jewson proves able to connect changes of medical practice and medical thinking during the period 1770–1870, to the social and economic relationships in terms of which doctors and patients interacted. By extension, his analysis offers fundamental insights into features of more familiar, twenty-first century systems of health care.

So how does the ‘sick-man’ fit into such a schema? Essentially, Jewson identifies three phases of medical practice—or, in his words, three types of medical cosmology. The first he calls bedside medicine. This is medicine as practiced on those wealthy enough—during the late eighteenth century—to employ the services of a physician. It is built around a speculative pathology; around ‘disease’ that travels through airs, bodies and systems, around a morbidity that is mercurial and defiant of location. Yet, it is also a medicine—and a form of medical practice—that is specifically tailored to the patient (sick man) considered as a Homo totus (if not in the religious sense, then at least in a modern secular sense). Such practice is, however, supplanted during the earlier part of the nineteenth century by hospital medicine. A key feature of this latter is the connection of disease and pathology to bodily organs—for every disease there is a site, for each pathology there is a lesion.
A physical examination of the patient's body—ante and post-mortem—emerges as a *sine qua non* of good medical practice. Yet, the sick man now becomes 'a case'; a frame for carrying organs and signs of disease. Symptoms, so central to the execution of bedside medicine, are now of only secondary importance. Then, toward the last third of the nineteenth century, another form of medical practice arises; Jewson refers to this as laboratory medicine. It is the medicine of cells and of cellular processes. It is also a medicine of microbes. It generates a form of practice, whereby 'the patient was removed from the medical investigator's field of saliency altogether' (p. 237), and where the claims and interests of the clinician became supplanted by the claims of the scientific research worker. During this phase, and to paraphrase Latour,3 pathology was moved out of the scientific research worker. During this phase, and to paraphrase Latour,3 pathology was moved out of the medical investigator's field of saliency altogether (p. 237), and where the claims and interests of the clinician became supplanted by the claims of the scientific research worker. During this phase, and to paraphrase Latour,3 pathology was moved out of the medical investigator's field of saliency altogether. It was 'Pasteurized'.

Now, has Jewson merely identified three phases in the 100-year period under consideration and had he merely associated different ideas with each one, then the paper might have been of limited interest, and certainly more than open to endless challenge from the curators of fine historical detail. Yet, he achieved much more than a categorization of historical phases, and he did so by adopting the Marxian claim that it is only by examining the totality of circumstances through which people reproduce their material lives that one can understand their ideas about the world. In particular, he illustrates how the 'sick-man' is not just an idea; a concept; but is a figure that arises out of the socio-economic relations between physicians and their (wealthy, independent) patients who can demand that they be treated as unique individuals. In the same way, the patient as a 'case' arises not merely out of new ways of thinking about disease, but is structured through a new set of relations—focused on hospitals as a place of study and treatment in which an emergent cadre of salaried, professional, independent physicians come to view human organs rather than human beings as their raw materials. Similarly, it is the material base of the laboratory that is connected to the production of science and a further new cadre of salaried scientific researchers who can drive medicine and medical practice forward in accordance with their interests (in cells and germs) rather than those of the clinicians—or, indeed, of the patients. Henceforth, the patient becomes not merely the subject of a professional clinical 'gaze', but also of the apparatus and enterprise of 'medical science'.

Jewson's focus on the 'patient' as a social category is strikingly novel, and he was certainly among the very first scholars to elevate the patient to the forefront of the history of medicine—to that vanguard previously peopled by famous men and a few women. More importantly, his approach to seeing doctor–patient relations as structured through the contingencies of material life has, I think, clear implications for an understanding of contemporary biomedicine and biomedical practice.

Now, it has been argued that what defines biomedicine is essentially a reconfiguration of relations between the state, clinicians, laboratory-based researchers and industrial corporations. Thus, with a specific focus on France and the USA, Gaudillière,4 for example, has traced the rise of biomedicine and big science through the post-1945 period and indicated how different configurations of biomedicine arose in those two countries—especially with regard to the role played by the state in financing health care. Yet, despite national differences in emphasis, Gaudillière argues that the essence of biomedicine is to be found in the dominance of the laboratory over the clinic. The inexorable bonding between those two entities and the alliance of biomedicine with global corporate enterprises has had substantial consequences for our understanding of what the 'patient' is, and how health care should be structured in the industrial world. So, what might these consequences be?

First, the dominance of biomedicine has undoubtedly encouraged the molecularization of the life sciences, and a subsequent tendency to genetiﬁ8 almost all forms of illness (including those that are solely defined in terms of behavioural traits). The *H. total* that was the sick man has little role to play here. Instead, human pathology in its various guises is invariably taken into the laboratory and isolated from its complex environmental contexts—as has been the case with modern medical approaches to breast, colorectal and other common forms of cancer. Secondly, the rise of biomedicine has encouraged a widespread belief among both lay and professional parties that there is a pharmacological fix for almost all human ills. This is a tendency that is, perhaps, most clearly seen in the psychiatrization of relatively minor mood and behavioural disorders, but is evident in the medicalization of the human condition in general.6 Thirdly, there is a focus on ‘being-at-risk’7 rather than being sick or diseased and a consequent tilt toward surveillance medicine in both professional and lay health-care practice—screening and self-care initiatives come to the fore. Fourthly, biomedicine almost by definition has encouraged the development of a medical–industrial complex, and a consequent commodiﬁcation of scientiﬁc knowledge8—most clearly seen, perhaps in the patenting of genetic mutations and the technology, materials and processes for identifying such mutations. Fifthly, biomedicine has encouraged the development of alliances between patients—via activist groups—and pharmaceutical corporations to have access to the ‘best care and treatment’ available for condition ‘X’. Connected to this has been a parallel emphasis placed on the autonomous individual as an independent (even ‘expert’) consumer of health care and health-care products—rather than as a passive ‘patient’.9
Finally, there has been an extension of market-based principles to the provision and organization of both primary and secondary health care. Of course a dyed-in-the-wool Marxist might be tempted to view all of these trends as ones instigated by big Pharma or other global corporate interests. Yet it is clear, from UK experience at least, that many of these trends are fostered and encouraged by the state itself—via its policies for ‘targeted’, ‘personalized’ and ‘tailored’ systems of health care in which the patient as independent consumer is paramount. It is this choice-burdened consumer who becomes allied with various interest groups (including corporations) so as to lobby the state for medicines, treatment and care procedures that serve the interests of some rather than most of the public. In any event, the ways in which contemporary doctor–patient relationships and systems of health care are structured is a product of many agents—consumers and policy makers every bit as much as scientists and corporations.

However, whilst the modern sick-man and woman are no longer viewed as ‘patients’, but as independent consumers with responsibility each for their own health, and expected to express that responsibility through choice and action in the health-care market, it is not, I would argue, because of any new cosmology. Rather, it is an expression of the everyday material circumstances in which we all live and medicine is practiced. I suspect that had Jewson written his paper in 2006 rather than 1976, he would have stated as much himself.  

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References