the tendency of the "load" to rush toward the back of the vehicle once the "operation" commences. For sheer evidentiary firepower, it may be the most powerful document in the book. But if it is intended as the keystone of Richie's argument about moral responsibility, what on earth is it doing in the afterword, and in a footnote?

The author's argument suffers too from a lack of comparison with other cities, even other German cities. Berliners will tell you that Berlin hated the Nazis, laughed at them as boors. But even in Nuremberg, people will cite election figures to show they never *really* supported Hitler—and Nuremberg has no *Gedaechtniskirche* or Reichstag, but a medieval sector rebuilt so perfectly that you'd never know it had been bombed. Berliners may have had doubts about resuming their status as capital and griped at the inconveniences of reunifying their city, but the very action of being forced to do so has meant endless confrontations with the historical ghosts Richie rightly wants to see given their due.

In her afterword, Richie suggests a more cautious and ultimately more workable definition of the moral culpability of her city, one drawn from Klaus Mann's *Mephisto* (1936), the story of a Berlin actor who starts out in the leftist opposition to the Nazis and is imperceptibly drawn into a level of collaboration and guilt that he never saw coming. "The warning of *Mephisto*," Richie writes, "is that a person makes his moral choice much earlier than he thinks." This sidesteps the fairly important question of whether there are any moral gradations between the writer of the memo about the gas vans and a Berliner who "merely" turned the other way as Jews were marched onto trains. Still, it is a valuable insight, one that condemns what ordinary Berliners did in the presence of extreme evil, but in terms that make it possible to connect that behavior to less spectacular failures, theirs and others', throughout history.

The idea that an individual, and likewise a nation, can fall into coresponsibility for ultimate evil merely by missing the chance to get off the bus is a persistent and chilling theme of this chilling century. Richie's evocation of it calls to mind the classic statement by the Polish poet and Nobel laureate Czeslaw Milosz in his early postwar poem about the end of the world. On the day the world ends, a bee buzzes sleepily in a flower, people go about their business, nothing much seems to have changed—except that a prophet by the riverside

> who is too busy to be a prophet
> mutters over and over again to his nets:
> "There will be no other end of the world,
> There will be no other end of the world."

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Defining Disease

MAKING SENSE OF ILLNESS:
Science, Society, and Disease.
By Robert A. Aronowitz, M.D.
Cambridge Univ. Press. 267 pp. $29.95

by Richard Restak

A successful attorney suddenly begins feeling listless and exhausted. Finding nothing amiss despite extensive tests, her doctors react with impatience, finally suggesting that she consult a psychiatrist. Eventually, and to her immense relief, another internist assures her that she does indeed suffer from an illness, chronic fatigue syndrome. The first doctors concentrated singlemindedly on a search for objective, testable criteria of disease; the last doctor heeded her sub-

jective feelings of illness. As another chronic fatigue sufferer put it, "The difference between a crazed neurotic and a seriously ill person is simply a test that would allow me to be ill."

A great deal depends upon whether society grants or withholds "permission" to be ill. If the rundown attorney's illness is confirmed, she may be eligible for medical disability, enabling her to retire with both economic security and social sanction. Without such confirmation, she not only will be deprived of any financial benefits but will likely be treated as an oddball, even a pariah.

In *Making Sense of Illness*, Robert A. Aronowitz, a professor at Robert Wood Johnson Medical School in New Jersey, argues that many shortcomings of our health care system result from the dominance of an "ontological view" of medicine, in which diseases unfold in all patients in characteristic and unvarying ways that can always be diagnosed by "abnormal" lab results. Under this model, doctors frequently tell patients with "normal" results, such as the attorney, that they are physically healthy (though perhaps psychologically unwell). And for some patients who feel just fine, doctors prescribe treatment because of abnormal test results. In place of the ontological method, the author advocates a holistic approach in which disease is understood—and treated—in the context of social factors.

As Aronowitz shows, doctors prescribe treatment for some patients with no symptoms whatsoever, owing to widespread confusion about testable risk factors. Hypertension, for instance, raises one's risk of stroke, heart attack, and other complications. But how much risk does mild and symptomless hypertension actually pose? And whatever the purported risk, shouldn't it be balanced against the risks associated with the medications that reduce blood pressure? Aronowitz sensibly suggests that "the proper definition of hypertension might be the threshold above which a particular individual has greater benefit from treatment than no treatment." Instead, doctors consider hypertension, no matter how mild, to be a disease in its own right. Buses and subways are plastered with ads encouraging people to monitor their blood pressure on a regular basis and tell their doctor of any deviation from "normal." As a result, "patients may view themselves as sick when they previously felt healthy. They may attribute all kinds of emotional states, behaviors, and health consequences to a new disease that has no experiential basis. They may make numerous physician visits not for any physical complaint, but to lower their statistical risk of disease."

As an additional complication, neither patient nor physician can be certain that today's accepted truths about risk factors won't turn out to be tomorrow's mythology. A prime example is cholesterol. Many people are convinced that the lower their cholesterol, the healthier they are. Doctors routinely treat patients to bring their cholesterol down to "normal" levels. Yet recent findings link low cholesterol with a serious risk of its own: an increased likelihood of suicide. It's speculated that cholesterol may represent a source of energy that, if depleted, contributes to depression, a major cause of suicide. So what, if anything, should a doctor do about a minimally elevated cholesterol level?

Risk-factor revisionism also touches less easily measurable variables such as personality. In 1961, San Francisco cardiologists Meyer Friedman and Ray Rosenman suggested that an increasingly stressful environment had given rise to the so-called Type A personality—marked by time urgency, hostility, and a generally hard-driving approach to life. Despite great initial enthusiasm for this concept (it remains firmly established in everyday parlance as a description of character and behavior), this pattern of behavioral traits hasn't panned out as a predictor of disease. Several studies have even found out that Type A patients are at *lower* risk for heart attack than others. An additional challenge to the Type A hypothesis is that the rate of heart attack has declined among all age groups, social classes, and races, despite

the absence of any perceptible decrease in our collective stress levels.

Overall, then, risk factors are a mixed blessing. They provide, at best, loose guidelines for healthy living. Aronowitz likens them to a list of ingredients: "Risk factor formulas are like mathematical statements of the probability of ending up with a particular bread as a function of different amounts of flour, water, yeast, eggs, and so on. In other words, the list of ingredients masquerades as instructions. One cannot make bread without a recipe."

In tracing the roots of our skewed definitions of sickness and health, Aronowitz casts a measure of blame on health maintenance organizations. Obsessed with objective data, they often define risk factors as diseases that require treatment, and they maintain that no disease exists whenever test results are within the normal range (which rules out many psychiatric disorders, among others). Under this approach, a healthy-feeling patient with elevated blood pressure is sick; the attorney incapacitated by constant fatigue is not.

Just as strict standards determine who is sick, they also increasingly determine how sickness is treated. HMOs have borrowed a principle from industrial production: if two patients with the "same" disease receive different treatments, one of them must be receiving inferior medical care. Doctors are forced to adhere to practice guidelines (typically formulated, to the joy of mathematicians, as algorithms) that must be applied in each medical "encounter." Deviations on the part of the doctor from these guidelines can result in admonitions, financial penalties, and sometimes expulsion from the "provider network." Patient guidelines are no less exacting. Failure to consult physicians on the proper "panel" or in the proper sequence, or to obtain approval for emergency care rendered by outside physicians, may result in a refusal of payment.

Aronowitz notes that "to the degree that medical care is thought of as the creation of a specific and unique product, like the manufacture of an automobile on an assembly line, then the equation of variability with poor quality holds some merit." But such an analogy fails to account for the individuality of the patient. The "same disease," the author argues, can never be "adequately understood as a set of uniform and predictable encounters between patients suffering specific ailments and physicians who apply specific diagnostic and therapeutic technology and practices."

Part of Aronowitz's message is that medicine is too important to be left to doctors. Ironically, though, earlier "demedicalization" of the health care system has led to some of the very problems he discusses, especially the loss of personal control. Social, legal, and political forces increasingly constrain doctors and patients alike. Doctors are forced to follow legalistic standards ("if it isn't documented, it didn't happen"). As a consequence, medical records now consist of extended, tedious, and obfuscating enumerations of normal findings, serving only to obscure from all but the most doggedly determined reader those key observations that furnish the basis for correct diagnosis and effective treatment. And patients find their health care determined not by themselves and their doctors but by bureaucrats, entrepreneurs, lawyers, and politicians.

The result is a widespread uneasiness about health care, the sort of uneasiness that was once limited to the poor and socially disenfranchised (whose care grows even worse). Among the middle class, the necessity of health insurance is forcing people to remain at jobs they detest. The wealthy are faced with draconian insurance rules that, in the case of Medicare, interfere with their willingness and ability to pay doctors more money in exchange for additional time and attention. And none of this is likely to improve in the near future. As Aronowitz notes, "demands for efficiency, uniformity, quality, and market discipline" are pushing medical care harder than ever. This important book shows that the dictatorship of quantifiable data will not soon give way.

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