Out of Hours

The reappearance of the sick man:

a landmark publication revisited

MEDICINE AS A SOCIAL PHENOMENON

There has been much cause to celebrate Leicester in the recent past, but this year marks a little-noted academic anniversary. Forty years ago, in the second of two seminal papers, Nicholas Jewson helped to recast medical historiography. Earlier historians of medicine focused on scientific developments, the origins of theories and treatments. Hitherto, intellectual progress had been regarded as the inexorable driver of therapeutic and institutional advance. A sociologist at the University of Leicester, Jewson was one of a new wave of researchers for whom medicine was a social phenomenon, shaped by wider political, economic, and cultural influences.[1]

Jewson was concerned in this paper with what he called 'the disappearance of the sick man' from medical cosmology in the period from 1770 to 1870.[2] He used the term 'medical cosmology' as shorthand for the prevailing theories and practices that defined the nature of medical discourse at that time. He sought to demonstrate how the social relations underpinning 18th-century medicine had been supplanted — with major consequences for knowledge and practice that endure to the present day.

JEWSON'S THESIS

Until the late 18th century, a system of 'bedside medicine' had prevailed in the Western world. In the Galenic tradition, diseases were thought to result from an imbalance of humours. Health was restored through various therapeutic actions and interventions devised to restore the disrupted equilibrium. Thus the sick man (or woman) was not viewed in isolation. Rather, an individual's psychological and social circumstances, behaviours, and life history were central to diagnosis and treatment.

In a paper published 2 years earlier, Jewson sought to show how this system was influenced by the economic power exercised by patients.[3] The fee-payer could choose the doctor who met their needs. The clinical encounter was also influenced by what Jewson called 'epistemological parity' — the extent of shared medical knowledge between practitioner and patient. The sick person's narrative was central to their encounter. The well-informed lay person at that time could converse on an almost equal footing with their physician.

Around 1800, a new cosmology or conceptual structure emerged in the form of 'hospital medicine' — first evident in post-revolutionary France, and then across the rest of Europe. This reflected a change in the space in which medical knowledge was elaborated and applied. The setting for bedside medicine was domestic: at home, the patient exercised more autonomy. The hospital, on the other hand, was the doctor's 'bailiwick'. Jewson was borrowing here from the work of Erwin Ackerknecht who first noted these distinctions.[4]

Existing power relations were unbalanced by an associated economic shift. Hospital patients came from all classes and were treated freely. Doctors looked for recognition and remuneration to professional peers rather than most patients. Increasingly, the discourse of hospital medicine employed concepts and technical language that were alien to lay understandings.

The new regime depended on three principal techniques. The first of these was detailed physical examination, supplemented by instrumental aids such as the stethoscope. The second was autopsy, which aimed to link symptoms to pathological bodily changes in the event of death. Finally, these correlations were analysed statistically to identify recurrent patterns of disease.[5]

The hospital patient's more dependent position allowed doctors to practise in ways that would have been impossible under the earlier dispensation. Physical examination of previously 'private' parts of the body, and autopsy, frequently violated conventional codes of decorum in the name of medical necessity. This shift in power relations was reinforced in other ways. At the bedside, doctors had offered prognosis and prediction that with treatment were the patient's main concerns. In hospital, the emphasis was on diagnosis and nosology. The patient ceased to be a person (or 'sick man' with his own agenda) and became a 'case' (or diseased body) contributing to the wider pool of medical knowledge.

This cosmological shift coincided in Britain, of course, with the emergence — after protracted battles with the Royal College of Physicians over licensing — of the forerunners of today's GPs: trained in medicine and surgery, plying their trade in the community.[6]

According to Jewson, another new cosmology emerged, particularly from German-speaking states, in the mid-19th century: 'laboratory medicine'. This sought disease at the cellular level and intensified the reductionist tendencies of the preceding stage. Clinicians could not detect pathogenic changes without a new set of skills. The locus for advancement and application of medical knowledge now became the laboratory, under the control of a new breed of scientific researchers. Lab scientists would over time become detached from the patient as they depended for their advancement on academic patrons. The gulf between the personal phenomenology of disease, and the technical terrain of the medical profession, continued to widen.

CRITICAL ADVANCES

Jewson's writings are not always easily accessible to the medical reader and they have been subject to much subsequent criticism. They are schematic rather than evidence-based. How well was the consilium (or management plan) of the 17th-century physic really understood by its recipient? Were not hospital practitioners quite as dependent on their reputations among the well-to-do? Was physical examination really absent from bedside medicine?

In fairness, Jewson was not suggesting that bedside practice was entirely eclipsed under the hegemony of hospital and laboratory medicine. Rather, he was exposing a change in the 'dominant mode of production of medical knowledge', or a shift in the 'locus

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of epistemological authority'.[7] His work has prompted further research, much of which substantiates his central thesis. For example, Mary Fissell's well-known study of Bristol Infirmary details how hospital wards came to be viewed as repositories of clinical material and surgical training grounds, as their control passed to surgeons from administrators.[8]

Sociologists have since sought to extend Jewson's cosmological sequence. David Armstrong has described the emergence of what he calls 'surveillance medicine' early in the 20th century.[9] This involves mapping disease not onto bodily components but onto societies and populations. 'Problematisation of the normal' began most obviously in the development of child health surveillance. Surveys have continued to break down the binary distinction of health from illness, transforming symptoms and signs into 'risk factors'. We all lie on a spectrum in terms of risks and degrees of ill-health. Armstrong's work provides a nuanced adjunct to those arguing against the medicalisation of normal life through screening and other forms of health promotion.

Sarah Nettleton has deftly described what she terms 'E-scaped medicine': the various ways that information and communication technologies are helping to transform medical knowledge and practice.[10] 'Scapes' are the networks of machines, technologies, organisations, and actors through which flow extraordinary amounts of information. The body itself is now an information-processing network; cyberscience is displacing the 'old biology'. Evidence-based medicine requires clinical decisions to be rooted in 'health intelligence' rather than the practitioner's wisdom. Today's medical students forgo specialist knowledge and clinical experience in learning how to access and use relevant information. Online sources yield more diffuse and varied forms of medical discourse that better meet the needs of more varied audiences. At the same time, E-scaped medicine is displacing health professionals and usurping their skills.[10]

WHY JEWSON IS RELEVANT TODAY

The term 'informational medicine' better encompasses the full impact of this ongoing cosmological shift. The medical gaze is nowadays refracted through computerised protocols and algorithms: first we check the template, then we listen to the patient. The screen has replaced the body as the emblem of contemporary medicine.[11] Those on the receiving end notice this disembodiment. In theory, the internet has empowered patients by extending the distribution of medical knowledge. Such knowledge is no longer so esoteric and 'expert patients' can manage their own conditions. In practice, for those less scientifically literate, the blessings of 'Wiki-medicine' can still be a source of confusion and vulnerability. Renewed calls for more holistic care, shared decision making, health coaching — these are just some of the ways we seek nowadays to re-enfranchise our patients. The sick man is reappearing, but often only in disgruntled outline.

Modern-day 'healthism' — so familiar to GPs — has been described as in part a response to the disappearance of Jewson's sick man.[12] This 'postmodern' phenomenon is characterised by high health awareness and expectations, information-seeking, self-reflection, and a partiality towards alternative, folk models of illness. All too often it is associated with mutually distrustful patient–professional relationships.[13]

Jewson is less well known to generations of doctors than contemporary iconoclasts such as McEwan, Illich, and Dubos. His grand trajectories are matched most obviously by those of Michel Foucault (another sociologist whose work has been justifiably criticised for lack of empirical evidence).[14] Historical studies have likewise qualified Jewson's ideas for the shifts he described were not inevitable. They occurred at different times, in different places, where circumstances supported new forms of medical practice.[5]

However, the essentials of Jewson's thesis ring true. There is a strong connection between medical knowledge and the power relations between patient and practitioner. We continue to grapple with the consequences of a move from person-centred to object-oriented health systems.

ADDRESS FOR CORRESPONDENCE

Stephen Gillam
Hill House, 3 Letheringsett Hill, Holt, Norfolk, NR25 6BL, UK.

E-mail: sjg67@medschl.cam.ac.uk

Jewson's framework for understanding the sweep of Western medicine has enduring resonance but, 40 years on, should we fear and lament the displacement if not outright disappearance of medical man (and woman)?

Stephen Gillam,
GP and Senior Visiting Fellow, Institute of Public Health, University of Cambridge, Cambridge.

DOI: 10.3399/bjgp16X688153

REFERENCES

1. Brunton D. Introduction. In: Brunton D, ed. *Medicine transformed. Health, disease and society in Europe, 1800–1930.* Manchester: Manchester University Press, 2004: xi–xviii.
2. Jewson N. The disappearance of the sick-man from medical cosmology, 1770–1870. *Sociology* 1976; **10(2):** 225–244.
3. Jewson N. Medical knowledge and the patronage system in eighteenth-century England. *Sociology* 1974; **8(3):** 369–385.
4. Ackerknecht EH. *Medicine at the Paris hospital, 1794–1848.* Baltimore: Johns Hopkins University Press, 1967.
5. Jacyna L. The localisation of disease. In: Brunton D, ed. *Medicine transformed. Health, disease and society in Europe, 1800–1930.* Manchester: Manchester University Press, 2004: 1–30.
6. Loudon K, Loudon I. *Medical care and the general practitioner, 1750-1850.* Oxford: Oxford University Press, 1987.
7. Nicholson M. Commentary: Nicholas Jewson and the disappearance of the sick man from medical cosmology, 1770–1870. *Int J Epidemiol* 2009; **38(3):** 639–642.
8. Fissell ME. *Patients, power, and the poor in eighteenth-century Bristol.* Cambridge: Cambridge University Press, 1991.
9. Armstrong D. The rise of surveillance medicine. *Soc Health Ill* 1995; **17(3)**: 393–404.
10. Nettleton S. The emergence of E-scaped medicine? *Sociology* 2004; **38(4):** 661–679.
11. Frank AW. Twin nightmares of the medical simulacrum: Baudrillard J, Cronenberg D. In: Stearns W, Chaloupka W, eds. *Jean Baudrillard: the disappearance of art and politics.* London: Macmillan, 1992.
12. Greenhalgh T, Wessely S. 'Health for me': a sociocultural analysis of healthism in the middle classes. *Br Med Bull* 2004; **69:** 197–213.
13. Gray JA. Postmodern medicine. *Lancet* 1999; **354(9189):** 1550–1553.
14. Foucault M. *Madness and civilization: a history of insanity in the Age of Reason.* New York: Random House, 1965.