IDEAS ON LIBERTY
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The Maternity Hospital and the Mental Hospital

At first sight, the maternity hospital and the mental hospital are two completely different institutions. However, on closer examination, striking similarities emerge.

Neither pregnancy nor delivery is a disease; each is an aspect of the mammalian reproductive mechanism. Women delivered babies long before there were special buildings called "lying-in hospitals" established to care for them. Behavioral reactions to the vicissitudes of life are also not diseases; they are aspects of the repertoire of human actions. In the past, people who displayed such behaviors prospered or perished, were celebrated or condemned, long before there were special buildings called "mental hospitals," ostensibly devoted to their care.

Modern medicine begins in the middle of the nineteenth century, with the development of the concept of disease as a pathological alteration of cells, tissues, and organs. This new understanding was made possible in part by advances in technology, and in part by the establishment of large municipal teaching hospitals. The live patients were the "case material" for clinical instruction, and when they died their corpses formed the "material" for the pathologist's postmortem examination.

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In England, hospitals began to be established more than a hundred years before the dawn of scientific medicine. These institutions resembled our current nursing homes and hospices more than they resemble our hospitals: they were way-stations to the cemetery. Most of their would-be beneficiaries viewed entering them with the same dread with which people now view entering a nursing home. When persons of rank and wealth fell ill, they were cared for and died at home. The aim of the early hospitals was social reform, not medical healing. Before the twentieth century, women from families with even modest means were rarely, if ever, delivered in maternity hospitals.

The development of mental hospitals followed a similar pattern. The early private madhouses were intended to help wealthy persons dispose of their unwanted relatives, by disguising coerced rehousing as care for insanity. After insane asylums became public institutions, in the eighteenth century, their inmate population consisted almost entirely of paupers. In hindsight, no medical historian doubts that, for the patients, the early hospitals did more harm than good. In the case of mental hospitals, this is still the case, with the judicial system and lawyers as additional beneficiaries.

Prior to the twentieth century, hospitals were places of horror. However, the harm they could do was limited by the fact that most of the sick people who went there were hopelessly ill and would have soon died in any case. This, however, was not true for

maternity hospitals and mental hospitals. The typical woman who entered a lying-in hospital was young and healthy. She would probably not have died had she delivered her infant at home. Her death was directly attributable to where she delivered, that is, the maternity hospital. Similarly, the typical person admitted to a mental hospital was a young adult in good health. Becoming a chronic mental patient was a direct consequence of being incarcerated for years in an insane asylum.

Identifying the Real Beneficiary

Looking back at the history of lying-in hospitals, Irvine Loudon, an English medical historian, writes:

> [T]he lying-in hospitals were from the early years plagued by recurrent epidemics of puerperal fever with appalling mortality rates. By *choosing delivery* in a lying-in hospital, women (although they seldom knew it) were exposing themselves to a risk of dying that was many times higher than it would have been if they had stayed at home in the worst of slums and been attended in their birth by no one except family and an untrained midwife. The lying-in hospitals were such a disaster that, *in retrospect*, it would have been better if they had never been established before the introduction of antisepsis in the 1880s. [*The Tragedy of Childbed Fever*, Oxford University Press, 2000, p. 59.]

Two points need to be made about this account. One is that women did not, as a rule, *choose* to be delivered in lying-in hospitals. Typically, they were dragged there by impoverished, overburdened relatives who wanted to be relieved of the duty of caring for them. The other point is that the detrimental nature of the lying-in hospital need not have been a retrospective judgment. It was obvious from the start, to many physicians as well as to many pregnant women. Physicians could not have helped but notice that puerperal fever occurred far more often among women delivered in such institutions than among women delivered in their homes.

During the first half of the nineteenth century, the medical profession, resting on new discoveries in chemistry and physics, began to acquire prestige and power it had not enjoyed in previous ages. Physicians claimed to have an explanation for virtually everything that ailed the human body. Puerperal fever was no exception: it was due to bad air, the so-called miasma theory. A few physicians dissented. In the United States, Oliver Wendell Holmes, and in Austria-Hungary, Ignaz Semmelweis, declared publicly that puerperal fever was a contagious disease, transmitted by the "dirty hands" of the doctors.

This was bad enough. But Semmelweis made another mistake: he proved it. He made medical students and doctors wash their hands with chlorinated lime water before examining patients: "So effective were his methods that between March and August of 1848 no woman died in childbirth in that division," Loudon writes. As a result, Semmelweis became living proof of the Hungarian proverb, "Tell the truth, and people will bash in your head."

Henrik Ibsen's famous play *An Enemy of the People* (1882) is the dramatic story of a doctor whose work and fate are loosely modeled after the tragedy of Semmelweis. Dr. Stockmann, a simple country doctor, tries to protect people from using the town bath contaminated with pathogenic bacteria. His discovery, however, conflicts with people's belief in the therapeutic properties of their treasured spa and jeopardizes their economic interests. The city's leaders and the public denounce Stockman as "an enemy of the people."

The waters Stockman denounced *had* to be therapeutic—lest the city's image be transformed from spa to a source of pestilence. Similarly, antipsychotic drugs *have* to be therapeutic—lest their forcible administration be transformed from treatment into torture; and schizophrenia *has* to be a brain disease—lest the medical legitimacy of psychiatry itself be undermined. □

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Capitalism and the Weak

by Daniel Hager

One allegation about capitalism is that it enables the strong to crush the weak. Some critics contend it models the ruthlessness of biological Darwinism's extermination of the weak through natural selection. In the Marxist view the entire proletarian class is enchained by the power of capitalists and must seize for itself the ownership of the means of production.

In reality capitalism *strengthens* the weak. Under capitalism the weak gain a degree of power not possible through other economic systems. One definition of capitalism is that it is a network of weaklings who combine their limited strengths to produce the unique personal power that accrues through abundance.

A vivid example of the strength of the weak under capitalism can be seen by considering the green seedless grape. This fruit has become such a staple in American supermarkets that its presence is no longer regarded with amazement. The domestic product is grown primarily in California. It is perishable. Yet it is available even 2,000 and 3,000 miles from there in top condition.

Another marvel added in the past two decades is that green seedless grapes are in supermarkets virtually year round even though California is a limited-source region in winter. Supplies have to come from some place where the weather is warm then, that is, the southern hemisphere. Chile produces most of the grapes marketed in the winter in North America. This highly perishable product reaches the stores after a journey of as much as 6,000 miles. Astonishingly, the volume is so plentiful that even the nonwealthy can consider a purchase.

Typically the American retail price per pound for green seedless grapes during the peak of the Chilean shipping season ranges from about $1.49 to $1.89 but lower during promotions. Based on a volume of 80 to 100 or more grapes per pound, depending on fruit size, the general non-sale price may be pegged roughly at two cents per grape.

The consumer who considers a purchase at that price is the weakest participant in the chain from vineyard to table. Most of us, if confronted with the challenge of securing green seedless grapes in February, would hardly know where to begin. One option would be to fly to Chile, buy grapes from a grower, arrange for shipment, then return home. The cost would be too high even to consider such a tactic. Yet, weak as we are, we have the power in the supermarket to decide either to buy grapes at only two cents each or to reject the retailer's offer.

Those elsewhere in the network are also weak. The grower may know how to grow grapes but falters at other points. He does not even have the strength to produce his crop without help from others. Mildew has been destroying grapes since at least the Old Testament times of Amos 4:9, and insects

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