Changing Perspectives in the Study of the Social Role of Medicine

DAVID MECHANIC

Rutgers University

THE WINTER 1977 ISSUE OF THE *MILBANK QUARTERLY* was the first published under the masthead of David Willis, its astute and skillful editor. From 1977 through 1990, David created a publication that searched out the major issues and explored them in depth, sensitive to their interdisciplinary character and historical origins. As a social policy journal in health, the *Quarterly* was unique in defining the broad policy context, in attracting many of the most interesting scholarly and research studies, and in anticipating the issues of the future. David always managed the journal as a labor of love, and was exemplary in carrying out every facet of publication ranging from his artful and charming solicitation of appropriate referees to his meticulous editing and encouragement of young scholars.

To the best of my knowledge, the process of shaping a scholarly journal so that it takes on a distinctive character has not been extensively analyzed. Certainly any journal in the field of health competes for outstanding papers and an editor is in large part captive of the submissions received. Yet the relationship between a well-edited journal and its potential authors is a sorting process in which editor and contributors are matched over time in interests, values, tastes, and general perspectives. This does not mean that papers with which editors disagree will not be published, but over time, through an invisible pro-

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cess, a fit develops between the orientation of a well-edited journal and the contributors and readers it attracts.

In this paper I explore varying themes important to the health care field that received prominence in the *Milbank Quarterly*. It is not clear to what extent these themes developed because the editor received attractive papers in these areas, but I have no difficulty discerning David's particular interests and perspectives, and his strong hand as a skillful editor. It is not simply an accident that the *Quarterly* approached policy issues broadly with concern for demography and history, and dealt with the important themes I review, often well before they became central to public policy discussion. In my review I give special attention to issues of disability, mental illness, and the transformation of medical work, in part because they were commonly a part of discussions in the *Quarterly*, but were generally neglected by other health policy journals.

David's first issue is illustrative of his efforts in the succeeding years to bring the insights of many disciplines to the critical examination of policy issues so as to break new ground. His opening performance as editor began with a lead article by Ernest Gruenberg, "The Failures of Success," now a classic. Gruenberg (1977), long connected with the innovative mental health activities of the Milbank Memorial Fund, traced how advances in medical technology that delayed mortality transformed the prevalence of chronicity and disability in the population, posing many new and unanticipated challenges. This essay was a suitable prolegomenon to what was to follow during the years of the Willis editorship because the journal took an early lead in deeply exploring such issues as the management of disability, an aging population and the growth of the oldest old, and the applications of technology in the later years of life.

Other papers in this initial issue also focused on the momentum of life-extending technologies and the challenges of containing costs. John Iglehart (1977), now special correspondent for the *New England Journal of Medicine* and editor of his own health policy journal, *Health Affairs*, examined the regulation of increasingly costly technology in the context of public values and responses that hailed each new advance. I wrote the third essay exploring the influences that were accelerating the growth of medical technology and the inevitable requirement of more evident rationing of health care (Mechanic 1977). Here I presented my initial formulation on concepts of rationing, examining the differences between rationing by fee and implicit and explicit rationing. I subsequently developed this approach further (Mechanic 1979, 1986), and rationing itself has become a key area both for policy studies (Aaron and Schwartz 1984; Blank 1988; Callahan 1986; Churchill 1987) and for new approaches to health entitlements, as in current efforts by Oregon to ration by redesigning benefits (Welch and Larson 1988). David's inaugural issue also had papers on hospital rate setting and the difficulties of developing an equitable and responsive health care system in New York under the operative fiscal constraints, issues that are even more salient today.

Throughout the 14 years, concerns about inequalities were a dominant theme. The journal, however, never approached inequality solely with the conventional emphasis on socioeconomic disadvantage. Contributions delved deeply into inequalities produced by stigma and devaluation because of age, disability, mental impairment, or lifestyle. The journal met high scholarly standards, but also was directed by a higher purpose focused on the enhancement of human dignity and social welfare.

Medicine and Society

People's troubles resulting from societal responses to age, disability, mental impairment, and lifestyle are particularly appropriate foci in broadly examining the role of medicine and its development in modern society. On the one hand, the loss of authority of other social institutions such as the family and church and the increasing impersonality of urban life put greater responsibility on medicine as a caring institution, one increasingly called upon to provide sustenance and support to distressed persons and to negotiate a variety of social tensions involving release from usual work and family obligations and access to sickness and disability benefits and other special entitlements. On the other hand, changing knowledge and technology, and the increasing subspecialization of medicine, resulted in a narrowing of medical perspectives and a growing aggressive focus on curative interventions. Certainly the boundaries of medicine grew to accommodate a broader range of social concerns than in earlier periods, but subspecialization developed more as part of a continuing stratification of medical work than as a way of bringing a holistic conception to medical practice.

By the 1950s social concern was mounting about the erosion of general medical practice, as were complaints about the lack of caring in medical transactions, even more evident today. The growing complexity of the medical division of labor made it inevitable that many of the social concerns of patients would be slighted and that some patients would be lost in the cracks. By the 1960s major efforts were being made to increase access to care by expanding physician supply and inducing physicians to assume primary care roles (Lewis, Fein, and Mechanic 1976). Considerable funds were invested in seeding family practice as a specialty area and in supporting residency programs in general medicine and pediatrics. The seeming logic of subspecialization in response to rapid knowledge development, reinforced by reimbursement arrangements that favored provision of discrete technical services, has sustained the specialization trend to the present, despite sustained efforts to reestablish a strong primary care sector.

A major psychosocial issue in primary care concerned the physician's role. Was the doctor's major responsibility simply to make a differential diagnosis and then apply the appropriate therapy, or was the expectation that doctors would try to understand and respond more deeply to why patients had come and their goals and expectations for treatment? A substantial body of research indicated that patients' motivations to seek care were often different from the manifest problems presented, and that a suitable outcome commonly depended on a process of negotiation (Mechanic 1978). Physicians increasingly trained in the new sciences and technologies of medicine were said to have little patience and even less financial incentive for the types of communication necessary to define and resolve patients' complaints within this broader conception.

One such important deficiency in primary care is the failure to recognize or treat depression, a disabling problem often motivating patients to seek care and complicating other medical conditions. Primary care physicians fail to recognize at least half of such conditions and generally underestimate their disabling consequences. Yet the evidence is persuasive that depressive symptoms, even short of a diagnosable clinical disorder, can devastate a person's life. Beyond the obvious risk of suicide associated with clinical depression, this condition also adversely affects almost every aspect of an individual's daily function.

In the RAND Medical Outcomes Study, a two-year prospective study of the well-being of 11,242 adult patients using alternative outpatient medical arrangements, eight chronic medical conditions, including hypertension, diabetes, advanced coronary artery disease, angina, arthritis, back problems, lung problems, and gastrointestinal disorders, were compared with depression on five functioning and well-being measures (Wells et al. 1989). The patients with depressive illness, as well as those with depressive symptoms short of a clinical diagnosis, performed more poorly on these measures than most of the patients with the other chronic diseases. For example, depressed patients reported higher bed disability than any other group with the exception of patients with advanced coronary artery disease. In addition, they had the poorest social and role functioning and assessed their health more poorly than any other patient group. The effects among depressed patients with comorbidity were additive.

Over the years, a large literature has accumulated on treatment of depression in general medical practice (Mechanic 1990). Efforts to encourage primary care physicians to better recognize and treat depression have met with mixed success, and research studies find that barriers to such behavior include poor training, negative attitudes, inadequate communication and interviewing skills, and organizational and financial disincentives (Goldberg and Huxley 1980; Mechanic 1974; Sartorius et al. 1990). Although much lip service is given to the importance of this area, it receives relatively low priority in medical education and in physicians' conceptions of their responsibilities.

Medical education is increasingly segmented by the enormous growth of biomedical science, the compartmentalization of departments, and advances in the clinical specialties. Almost everyone agrees about the need to bring the disciplines together into a holistic view of the patient, but the pressures and pace of daily efforts lead to inevitable neglect if such concerns are not explicit priorities. Most young physicians acquire limited concepts of problems, learning to focus on symptoms and disease, often neglecting underlying motivations that lead the patient to seek help. Yet if medicine is to enhance health as well as treat disease, physicians must develop some realistic capability to relate to people's troubles as they conceptualize them and to assist patients within their own frameworks of values and aspirations (Kleinman 1988).

Examining Alternative Models

Although the *Quarterly* seldom dug deeply into the psychological dimensions of medical practice, it actively sought to examine structural alternatives to conventional forms of medical practice and their consequences for access, quality, cost, and patient satisfaction. Always sensitive to historical background, David early in his tenure published two contributions by I.S. Falk. The first, appearing as the lead article in his second issue of 1977 (Falk 1977), examined proposals for national health insurance against the backdrop of Falk's work in the 1920s and 1930s on the Committee on the Costs of Medical Care (CCMC). The second, a commentary on a historical piece by Daniel Fox (1979) on economists and health care, included recollections of some of the controversies within the CCMC staff (Falk 1979). David's reach was both historical and comparative, and in examining structural alternatives, he brought to his readers fine contributions from such outstanding British policy analysts as Rudolf Klein and Brian Abel-Smith.

Consistent with the interest in the work of the CCMC, the *Quarterly* gave relatively large attention to health maintenance organizations (HMOs) as an alternative system of health care. In the spring 1978 issue, one of several important articles by Harold Luft first appeared (Luft 1978), examining the performance of HMOs. HMOs claimed a distinctive preventive orientation, but Luft showed that the amount of preventive services provided could be explained simply on the basis of the scope of insurance coverage. This was a particularly important observation because HMOs in their marketing were claiming they were different in their special motivation for prevention and early treatment to limit serious morbidity and were attributing performance outcomes to this ideology. Luft (1980) and others in subsequent articles in the *Quarterly* showed that the excellent financial performance of HMOs was the result of lower rates of hospitalization and surgical intervention, attributable to the types of incentives and controls under which prepaid group practices functioned. These early findings, which alternatively could be explained by selection effects, were sustained in the RAND health insurance experiment when the HMO that was studied, Group Health Cooperative of Puget Sound, demonstrated comparable economic advantages when patients in the experiment were randomized among alternative health insurance arrangements (Manning et al. 1984). The issue of selection was one given early attention in the *Quarterly*, with papers exploring in detail the types of persons who chose to join HMOs, their patterns of utilization and satisfaction, and how HMOs triaged patients and rationed services. Attention was also given to the implications of risk selection for pricing and the emergence of a realistic competitive marketplace.

Visions of the Future

In the years of David's editorship, the *Quarterly* touched on most issues of policy importance, but its special character derived less from its scope and more from the types of special issues it chose to highlight. These special issues became the "soul" of the journal, focusing attention on alternative ways of viewing the medical enterprise, neglected populations, and impending challenges. In focusing on such concepts as diseases of society, disability and independence, cultural responses, the negotiation of explanatory schemes, and personhood, it brought to health policy considerations a depth of discussion that was visibly absent as our society increasingly became obsessed with health care costs. The mark of the journal was its passionate concern with issues of inequality and equity, and it kept before us the special problems of the deinstitutionalized mentally ill, the disabled, the oldest old, persons with AIDS, and the socially disadvantaged.

Viewed as a whole, these special themes sought to maintain our awareness of the inextricable connections between health and society, their persistence through time, and their linkage to demographic transitions. Within this context, the *Quarterly* was searching meaningfully for alternative frameworks of health care responsive to the risks of disadvantage, the need for access, and problems associated with lack of insurance and uncompensated care. These, of course, are common areas of discussion within our field, but what made these thematic issues special was the obvious stretch for an appropriate paradigm that embodied what some have called the "new morbidity" and the challenges of long-term care, not only for the elderly, but also for the disabled, the mentally ill, and persons with AIDS.

Disability and Independence

The focus on disability was emblematic of how the editor sought out thoughtful analyses and empirical work on processes that tied the workings of society to issues of health and disease and broader welfare policies. In the introduction to the special supplement on this topic, Fox and Willis (1989) note that discussion of disability policy was a convenient way

> . . . to characterize interventions that seek to enable people with impairments to live in ways that are personally satisfying and socially

> useful. . . . Disability policy is the result of complicated and continuous social negotiations. These negotiations involve elusive and continually changing definitions of impairment and handicap, of the rights and obligations of individuals, of collective responsibility, of the economic need for and the value of work, and even of national interest. (Fox and Willis 1989, 1)

Disability captures the interplay between the needs, aspirations, motivations, and capacities of individuals and the organization of their environment that either enhances their opportunities for involvement and participation or places barriers that make them dependent. The underlying message was that disability was not an attribute of persons, but rather a result of the fit or lack of fit between personal characteristics and the physical and social environments in which persons functioned. The disability rights movement made clear that barriers to independence were as much a result of public attitudes, inaccessible work settings and public places, and arbitrary restrictions on social participation as they were a product of personal impairments.

This social model of disability is paradigmatic of insights essential to future configurations of health care. The medical care system overwhelmingly deals with the manifestations of chronic disease in later life. The prevalent view of disease from an episodic perspective commonly fails to capture the complex interplay between the trajectory of disease and the family, work, and community conditions that affect function and quality of life. Medicine needs to move beyond physical function to address how care and social support can facilitate continued participation in relation to individuals' abilities, preferences, and valued social connections. Training of health professionals requires a broad perspective that views interventions not only from the perspective of changing individual attributes, but also in terms of the modification of social arrangements to foster choice and independence. This requires not only appropriate instruction of patients and engaging their families and caretakers to facilitate productive arrangements, but also structural rearrangements.

An examination of disability policy affirms Rudolf Virchow's essential insight that medicine is in essence a social science. Every society must ensure an adequate work force, yet compassion requires that the sick and disabled be excused from usual obligations and receive assistance. These opposing needs are adjudicated through the social construction of meanings of sickness and disability and their application to individual cases. The challenge in any society is meaningfully to assist those in need without developing incentives that encourage individuals to escape their familial and work obligations. Definitions have evolved over a long history, shaped by cultural patterns and reflecting changing demography, social organization, and societal needs.

In the United States, the elaborate disability system that evolved under the Social Security Act underwent a large expansion in the 1970s. A vigorous debate has occurred in the past 15 years about the interconnections between the disability system and labor market behavior, with some claiming that increases in benefits under Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) were undermining incentives to work. In 1980, the Congress, generally alarmed about mounting program costs, required states to review eligibility of recipients at least every three years, beginning a process of removing large numbers of people from the disability rolls. Between 1981 and 1983, half a million recipients were terminated from the program, resulting in massive litigation in the federal courts and reinstatement of some 290,000 enrollees (Osterweis, Kleinman, and Mechanic 1987).

Disability is, as we have noted, a social process depending on both individual capacities and motivations and the social and environmental settings with which they interact. Highly motivated persons with extraordinary impairments are often able to work and participate fully in life affairs, whereas others have great difficulty with impairments that seem much less profound. Disability determinations thus are discretionary judgments involving assessment of the characteristics of persons, their community context, and the existing features of the labor market.

The disability system, however, was not established to make eligibility easy. Although the Social Security Administration (SSA) adopted a medical definition of disability, it did not leave such determinations to physicians, who it assumed would too readily accept individual claims. Nor did it wish to take into account whether there were realistic opportunities to work, but rather established rules making individuals ineligible if there was work they could perform even if it was not immediately available in their locality. A basic motivation was to separate the notion of disability insurance from unemployment insurance. In fact, the evidence showed that numbers of disabled enrollees increased during periods of economic stress, and over time disability policy became increasingly pragmatic, loosening criteria for older workers approaching retirement age and workers with limited education and job skills (Osterweis, Kleinman, and Mechanic 1987).

The conditions for an effective disability system are also those that create obvious dilemmas and tensions. While trying to be responsive to the "truly needy," the system also seeks to sustain the societal commitment to work and independence, and to contain welfare expenditures. Achieving these somewhat conflicting goals requires considerable discretion, but discretion inevitably results in lack of uniformity of administration. It seems reasonably clear that gaining eligibility depends on how clients construct their claims, obtain the necessary medical documentation, and persist in the face of extensive bureaucracy. The bureaucratic procedures are designed to be fair and allow several levels of appeal and review. One persistent difficulty from SSA's perspective is the frequency with which administrative law judges who hear appeals for the SSA reverse eligibility denials (Mashaw 1983). SSA attempts to constrain these decisions, creating tensions among varying components of the disability determination system. One consequence is that attaining eligible status is enhanced by expertise and legal and other advocates who understand the determination process and appeals procedures.

In the eligibility reviews of the 1980s, large numbers of seriously mentally ill persons lost their disability benefits, but many were subsequently reinstated by the courts. The mentally ill were a targeted group in part because of their young age and also because their limitations varied from the medical stereotypes that commonly prevailed within the disability system. Eliminating such clients from dependence on the disability system appeared to promise large future savings because of their relatively young age, but little consideration was given to the capacity of many of these persons to work under the usual social pressures and stresses of employment. The disruptive litigation that resulted from these efforts encouraged the SSA to work closely with the American Psychiatric Association in developing a more realistic assessment approach that examined the ability of these clients to function in a work setting.

The Challenge of Mental Illness

The special difficulties of the mentally ill within the disability determination process was only one aspect of the multitude of problems they face. The Milbank Memorial Fund has had a long and distinguished history in addressing mental health issues, linked to the transformation of mental health services in the 1955–1980 period. Beginning in the late 1940s, the Fund brought together social scientists and psychiatrists through conferences and other meetings to encourage research on socioenvironmental issues and to consider future mental health policies (Grob 1991). Through its emphasis on socioenvironmental issues and community-oriented programs, it played a major role in establishing the epidemiological basis and intellectual rationale for the community care movement that emerged in the 1960s.

By the late 1970s it was evident that the promises of deinstitutionalization had not been realized. Although large numbers of patients were discharged from public mental hospitals, and admission was increasingly difficult, an adequate framework of community care had not been developed, and there was persistent evidence of neglect of the seriously mentally ill. Mental health care in general hospitals, community mental health centers, outpatient clinics, and office-based practice increased enormously, but for the most part these services were not directed to the most seriously ill and disabled patients. In the fall of 1979, the *Quarterly* devoted a special issue to examining deinstitutionalization, both its potential value and its failures. Using a comparative U.S. and British perspective, this issue presented a tough-minded call to abandon rhetoric and seek evidence of efficacious outcomes. Characteristic of the contributions was one by Ernest Gruenberg and Janet Archer (1979), decrying the abandonment of the seriously mentally ill and calling for fundamental reappraisal of the organization of care with the goal of a unified system of services. As they noted:

> The primary focus of attention must be on that group of chronic mental patients who benefit least from the existing fragmented pattern of services. For these people, it is necessary to have unified clinical and social service teams that can take ongoing responsibility for them, both when they are living in a hospital and when they are living in the community, and can become familiar with the social and clinical resources that can be used to help them function. (Gruenberg and Archer 1979, 503)

Little of the pragmatic wisdom in the fall 1979 issue was evident in the public policy arena in the 1980s as services and life conditions for the seriously mentally ill deteriorated (Mechanic 1989). In the 1980s homelessness became a growing problem and significant numbers of seriously mentally ill persons were on the streets. Many factors contributed to deinstitutionalization in the period from 1955 to 1980, but it was only with the expansion of the social welfare programs of the 1960s and 1970s that massive transfer of patients to community settings became possible. Although many of the enabling factors for deinstitutionalization such as community ideologies, neuroleptic drugs, and changing administrative attitudes were evident a decade earlier, deinstitutionalization initially proceeded slowly because of the lack of appropriate residential placements and inadequate subsistence. The pace of deinstitutionalization dramatically increased with the expansion of social welfare opportunities in the mid-1960s, with the growth of the nursing home industry stimulated by the Medicaid program, and with new opportunities for states to shift costs to the federal government under Medicaid (Gronfein 1985; Mechanic 1987).

During the Reagan administration there were major cutbacks in the social welfare programs that affected the seriously mentally ill. Such programs as SSI, low-income housing programs, and Medicaid either contracted or failed to keep pace with the growing poor population. The changing demography of the population, and the advance of the baby boom cohorts to young adulthood, a period of high incidence of major mental illnesses, made it inevitable that there would be larger numbers of seriously mentally ill youth, but the welfare system had become less responsive and supportive (Mechanic and Rochefort 1990). The crisis of mental health services in the 1980s and 1990s in part results from a failure in welfare.

The Transformation of Medical Work

Throughout David's stewardship, the *Quarterly* sought to define the emerging changes in medical technology and organization, and the character of the health professions. Much of this focus dealt with pressing policy issues such as the appropriate assessment and regulation of technology and approaches to establishing a vital primary care sector. What made the *Quarterly* special, however, was its inclination to dig beneath the salient policy issues to examine the social, cultural, and professional consequences of the emerging organizational changes. One such special issue thus focused on the changing character of the medical profession itself (Willis 1988).

The work of the physician and the conditions of practice have undergone dramatic changes over the past 30 years. Where medicine was once a bastion of independent entrepreneurial expression, with physicians viewing themselves as authoritative agents of their patients, physicians now find themselves constrained by organizations, government, and other third-party payers, changed patient expectations, and a variety of new review procedures. Physicians more commonly work in groups and for large organizations, must accommodate their wishes to organizational demands and the needs of other professionals, and more frequently than before are affected by financial incentives and constraints over which they feel little control. Under the influence of managed care, many see their roles shifting from being an advocate for the patient to one involving allocation of resources among competing needs (Mechanic 1986). Patients appear more informed and demanding and less deferential, and the media contribute to a growing distrust of physician motives and competence.

Some believe that the industrial revolution has caught up with medicine, divesting physicians of control over the means of medical work. They use the clumsy term "proletarianization" to characterize this process and the growing bureaucratization of practice. Challenging Eliot Freidson's model of medical dominance (Freidson 1970), a description they say applies only to an earlier era, they argue that physicians have less control than before over criteria for entering the profession, the content of training, the manner in which medical work is carried out, the selection of clients served, technology and facilities, and, finally, remuneration arrangements (McKinlay and Stoeckle 1990). Changes eroding medical autonomy have certainly occurred, but their significance for understanding the position and role of medicine are different from their effects on the individual doctor's sense of autonomy. The importance of medicine as a social institution, the resources devoted to its development and practice, and its boundaries relative to other societal institutions have, in recent decades, all expanded. Moreover, the basic assumptions and approaches that drive the development of health care, health research, and professional education and practice closely follow traditional medical models. Despite rhetoric about health promotion and biopsychosocial models, the medical definitions continue to define the cutting edge. Some health professionals like nurse practitioners and psychologists have found practice niches, free from the control of physicians, but to emphasize these neglects the continued medical dominance of health science centers.

Despite growing reservations about the imperatives of technology and its unevaluated diffusion, technological momentum persists and accelerates. Moreover, after 30 years of efforts to revive the role of primary care, reimbursement and prestige continue to reinforce trends in medical subspecialization. The ruling paradigm in health care continues to be quintessentially medical, and even efforts to examine effectiveness follow these relatively bounded perspectives. The media may give much attention to health promotion, holistic health, and quality of life, but these ideas are readily absorbed into ongoing activities without diverting the mainstream.

The Vision of Alternative Paradigms

To assert that no paradigm today competes seriously with medical conceptions is not to suggest the absence of alternative visions. Public health is a powerful vision, oriented to the identification and remediation of the conditions in society that contribute to morbidity, disability, and mortality. Unlike medicine, public health adopts a population perspective seeking to address social conditions as well as personal factors. By the beginning of the century, the value of this perspective was evident in addressing the transmission of infectious disease. As the century progressed, however, conceptions of community intervention not only competed with the practice interests of medical practitioners, but also with broader economic interests. A robust conception of public health inevitably conflicts with the priorities of other institutions and private beliefs, and possible mandates for public health efforts have been clearly circumscribed by a variety of economic, religious, and medical interests (Starr 1982). Yet it would not be difficult conceptually to design major realignments of expenditures to give public health efforts greater primacy. The data are overwhelming that much of poor health derives from material disadvantage and other social conditions (Bunker, Gomby, and Kehrer 1989), but we seem more prepared, for example, to invest enormous sums in neonatal intensive care and other high-tech medical interventions than to ensure such basic needs as prenatal and child care and immunization. Our individualistic ideologies make it inevitable that public health will have reduced potential in American society, but even within these political constraints we fall well short of what is feasible (Institute of Medicine 1988). Compassion is more easily attached to the plight of individuals in distress than to population aggregates, and although public health has been assimilated to some degree into medicine, its position is better seen as shaped by blocked opportunities than by a vigorously competing orientation.

Competing visions exist as well in the area of general clinical medicine, but remain underdeveloped. As the burden of illness has shifted to irreversible chronic and degenerative diseases, the challenges of care are increasingly involved with restoration of function in some meaningful relationship to people's goals and aspirations. Among the old, and oldest old, disease is ubiquitous. The most important function of care involves assisting individuals to accommodate to disease and impairments in a manner that maintains their ability to function in valued social roles.

Physicians are trained to view patients through a relatively narrow lens. For many patients with chronic disease, however, a definitive diagnosis and small alterations in medical management are less important than receiving assistance in learning how to live satisfactorily with a disorder and its consequences. This may involve moderating patients' medical regimens to better fit their life style and goals, helping locate appropriate community supports, or identifying aids and technologies that allow an essential function to be maintained.

This paper has referred to only a small sample of areas that were given prominence during David's editorship over a 14-year period. I hope it has captured that special quality that scholars in health policy recognize as its unique contributions. This period in the history of the *Milbank Quarterly* has been remarkable, and its contributions far exceed what might have been anticipated from its frequency of publication or number of subscribers. During the years of David Willis's editorship, the *Quarterly* was particularly important in exploring the crucial links between health and society and the special needs of the disadvantaged and disenfranchised. Perhaps most important, the journal through all these years conveyed a vision of a more equitable and effective health care system sensitive to the practical realities, but always dedicated to keeping moral issues in the forefront.

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Address correspondence to: David Mechanic, Ph.D., Director, Institute for Health, Health Care Policy, and Aging Research, Rutgers University, 30 College Avenue, New Brunswick, NJ 08903.