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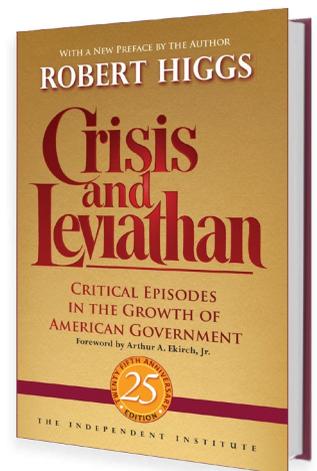
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The Therapeutic State

The Tyranny of Pharmacracy

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THOMAS S. SZASZ

One of the symbols of sovereign states is the postage stamp. Traditionally, U.S. stamps have depicted a famous American or an important historical scene. In 1893, to increase revenues, the U. S. Post Office began to issue commemorative stamps. The first stamps with health-related themes—for example, a stamp depicting children playing and smiling, commemorating the centennial of the American Dental Association—appeared in 1959. In 1999, the Postal Service unveiled two stamps emblematic of the escalation of America’s wars on diseases. On one, the inscription recommended, “Prostate Cancer Awareness: Annual Checkups and Tests”; on the other, it exhorted, “Breast Cancer: Fund the Fight. Find a Cure” (Woloshin and Schwartz 1999).

The Medicalization of Politics

Webster’s Third New International Dictionary defines the state as “The political organization that has supreme civil authority and political power and serves as the basis of government.” Instead of offering definitions of the state, political scientists prefer to identify its characteristic features, such as the possession of “organized police powers, defined spatial boundaries, or a formal judiciary” [and] “a deep and abiding association between the state as a form of social organization and warfare as a political and economic policy” (Fried 1968, 143, 149). I regard monopoly of the legitimate use of force as the quintessential characteristic of the modern state. In this article, I focus on the beliefs and values that justify the possession of such force and the aims it serves.

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The need to justify the use of force seems instinctive. For the child, the parents' power to coerce—by word or deed, intimidation or punishment—appears justified by their superior wisdom and by the child's innate lawlessness and socially imposed duty to become domesticated. The combination of the natural authority of the superiors, the natural nonconformity of the subordinates and their need to learn the rules of the game and to adhere to them, and the supreme importance of the welfare of the group (family, society, nation), which rests on conformity to social convention, form the template for religious, political, and medical justifications of coercive domination.

Three familiar ideologies of legitimation result: theocracy (God's will); democracy (consent of the governed); and socialism (economic equality, "social justice"). In 1963, in *Law, Liberty, and Psychiatry*, I suggested that modern Western societies, especially the United States, are developing a fourth ideology of legitimation: "Although we may not know it, we have, in our day, witnessed the birth of the Therapeutic State" (212). Since then, in articles and books, I have described and documented the characteristic features of this polity: medical symbols playing the role formerly played by patriotic symbols and the rule of medical discretion and "therapy" replacing the rule of law and punishment (see Szasz 1965, [1970] 1977, 1980, 1982, 1984, 1994a, 1994b, 1995, 1996).

It is undeniable that the state is primarily an apparatus of coercion with a monopoly of the legitimate use of violence. "Government," warned George Washington, "is not reason; it is not eloquence. It is force. Like fire it is a dangerous servant and a fearful master" (qtd. in *Cato Newsletter*, June 1, 2000, 1). Hence, as the reach of the legitimate influence of this "fearful master" expands, the sphere of personal liberties contracts. What, then, ought to belong to the state, and what to the individual? The history of the West may be viewed in part as the history of the growth of freedom, characterized by a lively debate about where to draw the line between the state's duty to safeguard the interests of the community and its obligation to protect individual liberty. Accustomed to hearing phrases such as "freedom of religion," "freedom of speech," and "the free market," we recognize that each refers to a set of activities free from interference by the coercive apparatus of the state. Should we similarly possess "freedom to be sick," "freedom to make ourselves sick," "freedom to treat ourselves," "freedom to obtain medical care," and so forth?

Informed debate about where to draw the line between the welfare of the community and the health of the individual requires that we be clear about the legal distinction between public health and private health. Edward P. Richards and Katharine C. Rathbun—a law professor and a public-health physician, respectively—explain: "Public health is not about making individuals healthy; it is about keeping society healthy by preventing individuals from doing things that endanger others" (1999, 356). Hence, preserving and promoting public health often require coercion, whereas preserving and promoting private health require liberty and responsibility. "Persuading people to wear seatbelts, treat their hypertension, eat a healthy diet, and stop smoking," Richards and Rathbun continue, "is personal health protection. Stop-

ping drunk drivers, treating tuberculosis, condemning bad meat, and making people stop smoking where others are exposed to their smoke is public health. . . . *Public health should be narrowly defined* in terms of controlling the spread of communicable diseases in society” (1999, 356, emphasis added). Instead of confronting the differences and conflicts between public health and private health, politicians, physicians, and lay people debate slogans, such as the right to health, a patient’s bill of rights, patient autonomy, war on drugs, and war on cancer.

Medical Ideology and the Total State

In the nineteenth century, when scientific medicine was in its infancy, disease was defined by pathologists; effective remedies were virtually nonexistent; the term *treatment* meant medical care sought and paid for by the patient; and the state showed little interest in the concept of therapy.

Today, when scientific medicine is a robust adult, physicians routinely effect near-miraculous cures; politicians and their lackeys, led by Surgeons General, define disease; the state shows intense interest in the concept of disease; and the term *treatment* is often used in lieu of the term *coercion*.

Fifty years ago, few Americans others than politicians and physicians knew there was a bureaucrat in America called the Surgeon General. Today, he is America’s Physician General, preaching ceaselessly from the bully pulpit—a symbol and symptom of pharmacocracy and of the growing power of the therapeutic state. Dan E. Beauchamp, an emeritus professor at the State University of New York at Albany, hails the sudden prominence of the Surgeon General as a sign of the “democratization” of health policy. He writes: “The role that democratic discussion now plays in health policy is perhaps best illustrated by the radical redefinition of the role of the U.S. Surgeon General from head of a rather obscure commissioned officer corps of the Public Health Service to our leading national spokesman on public health issues” (1988, 136).

Rudolf Virchow (1821–1902), the father of modern pathology, longed for a future in which the physician qua Platonic philosopher would serve as a guide to the politician-king. “What other science,” he asked rhetorically, “is better suited to *propose laws* as the basis of social structure, in order to make effective those which are inherent in man himself?” ([1849] 1958, 66, emphasis added). He suggested that “Once medicine is established as anthropology . . . the physiologist and the practitioner will be counted among the elder statesmen who *support the social structure*” (66, emphasis added). Virchow was politically naive: he thought the future doctor would be a solid scientist and a wise leader instead of, as is the case, a bureaucratic toady ignorant of scientific medicine. Furthermore, if the physician’s task is to support the social structure, his actual job may be to harm, not help, the person called the “patient.”

We know that the proposition that *medical practice* is a science cannot be true (see Szasz 2001, chap. 3 and 5). Nevertheless, the idea is superficially attractive, even

plausible. To resolve human problems, all we need to do is define them as the symptoms of diseases and, presto, they become maladies remediable by medical measures.

Medicine and the Metaphor of War

The illnesses first understood and conquered by scientific medicine were the infectious diseases. Because the response of the immune system to pathogenic microorganisms is readily analogized to a nation resisting an invading army, the military or war metaphor has become congenial in thinking about illness and treatment. When we speak about microbes “attacking” the body, antibiotics as magic “bullets,” doctors as “fighting” against diseases, and so forth, we use metaphors to convey the idea that the doctor is like the soldier who *protects the homeland from foreign invaders*. However, when we speak about the war on drugs or the war on mental illness, we use metaphors to convey the idea that the state is like a doctor when it uses doctors as soldiers to *protect people from themselves*. In one case, we speak about doctors helping patients to overcome *diseases*, in the other about doctors preventing citizens from *doing what they want to do*.

In the case of infectious diseases—the microbe as alien pathogen threatening the host (the patient’s body)—the war metaphor helps us understand the mechanism of the disease and justifies the coercive segregation (quarantine) of contagious persons, animals, or materials. In the case of psychiatric diseases—the war metaphor casting the mental patient in the role of alien pathogen threatening the host (society)—the metaphor prevents us from understanding the problem misidentified as a disease: it convinces the patient’s family, society, and sometimes the patient himself that the mental patient *is* (like) a pathogen, justifying the coercive segregation of the subject as “dangerous to himself or others.” Failure to understand the abuses of the military metaphor in medicine and psychiatry precludes perceiving medical coercion as a problem.

Viewing the state as primarily an apparatus of coercion with a monopoly of the legitimate use of force does not commit one to denying that the state can do good as well as evil. Probably no individual or institution is exclusively inclined to do evil. Moreover, doing evil to some often benefits others. The paradigmatic organ of the state is the army, which Robert Heinlein aptly characterized as “a permanent organization for the destruction of life and property” (qtd. in Porter 1994, xiii). The fact that armies are deployed to rescue people and help guard property after natural disasters does not alter their primary role.

It took centuries of terrible wars before people began to recognize that because the *state is*, par excellence, an instrument of violence, whereas the *church ought to be*, par excellence, an instrument of nonviolence, the two should get a divorce or at least a legal separation. Medicine and the state also ought to get a divorce, with primary custody of the citizens (as potential patients) granted to themselves and institutionalized medicine given only visitation rights. However, we do not view the relationship

between medicine and the state the same way we view the relationship between church and state. The reason may be that the physical illness of the individual, unlike his spiritual illness, can *directly* affect the physical health of the group. That relationship has justified certain public-health measures as legitimate instruments of state coercion. However, this reasoning does not justify state coercion as a morally legitimate instrument for protecting people from themselves. What should be the role of the state with respect to protecting the individual from diseases that do not by themselves pose a threat to others?

- Should protecting one's health be the responsibility of the individual, just as it is his responsibility to feed and house himself and provide for his spiritual health?
- Should the state assume responsibility for providing "health care," as it used to assume responsibility for providing "religious care" (a responsibility it still assumes in many parts of the world, even in some societies where church and state are in principle separated—for example, Germany and Switzerland)?
- Should the state assume responsibility for protecting the individual from himself if in the opinion of medical (psychiatric) experts he poses a danger to his own health and well-being?

In my view, the coercive apparatus of the state ought to be as separate from the professional treatment of medical illness as it is from professional treatment of spiritual illness. Such a separation of medicine and the state is necessary for the protection and promotion of individual liberty, responsibility, and dignity.

Because the state has a monopoly of the legitimate use of force, it is the only institution legally empowered to wage war (and punish crime). Although the Constitution reserves to Congress the ultimate authority to engage the nation in war, that restraint is no longer operative. Since the end of World War II, American governments have waged wars, abroad and at home, on the basis of bureaucratic regulations and executive orders. Some of these wars have been justified on essentially medical grounds, for example, the invasion of Panama. Illustrative of how far the blending of the concept of disease with the concept of war has gone is the declaration by the president and the secretary of state in June 2000 that AIDS in Africa poses a problem to America's *national security* (both are qtd. in Buckley 2000, 62–63).

Regardless of why the government sends military personnel to foreign countries and of whether those in command call the operation "peacekeeping" or a "war on narcoterrorism," the deployment of such force is an act of war. The enemy may be literal, an invading soldier, or metaphorical, a crop or chemical. The Germans and the Japanese in World War II were literal enemies. The people who cause unrest in Haiti or Somalia, the peasants who grow coca in Colombia, the "drug lords" in Mexico, and the substances the government bans are metaphorical enemies. We sow

metaphors of war and reap literal violence. The fight against polio, let us remember, was called the March of Dimes, not a “war against polio,” and it entailed no participation, assuredly no use of force, by the government. We ought to view America’s unending wars on diseases and drugs against this background.

To understand our present dilemma, we must understand the growth of the American state, especially since the Roosevelt years (see Flynn [1948] 1998). The United States has become a complex, bureaucratic, regulatory, welfare state—a condition brought about by means of the time-honored political tactic of declaring a national emergency and requiring that all of the state’s “human resources” be mobilized. “Every collective revolution,” warned Herbert Hoover (1874–1964), “rides in on a Trojan horse of ‘Emergency.’ It was the tactic of Lenin, Hitler, and Mussolini. . . . This technique of creating emergency is the greatest achievement that demagoguery attains” (qtd. in Higgs 1987, 159). The infamous George Jacques Danton (1759–94) declared: “Everything belongs to the fatherland when the fatherland is in danger” (*Bartlett’s Familiar Quotations*, 16th ed., 364). Two years later, the fatherland repossessed his head. To the executioner about to guillotine him, he said: “Show my head to the people” (*Encyclopedia Britannica* 7:64).

In *Crisis and Leviathan* (1987), Robert Higgs expands on this theme. “Knowing how the government has grown,” he observes, “requires an examination of what, exactly, the government does: the growth of government has resulted not so much from doing more to accomplish traditional governmental functions; rather, it has resulted largely from the government’s taking on new functions, activities, and programs—some of them completely novel, others previously the responsibility of the private citizen”(x). Higgs’s thesis is that government expansion has been nurtured by a succession of “crises” that the government proceeds to “fix.” After a crisis subsides, the new government functions remain, heaping bureaucracies upon bureaucracies. Although Higgs does not include health emergencies among the crises he discusses, they belong on top of the list.

Despite the evidence I have presented, well-respected social analysts maintain that the power and scope of the state are dwindling. In *The Rise and Decline of the State*, Martin van Creveld, a professor of history at Hebrew University in Jerusalem, writes: “The state, which since the middle of the seventeenth century has been the most important and most characteristic of all modern institutions, is in decline” (1999, vii). How does Creveld arrive at this conclusion? By emphasizing growing popular resistance to the cost of socialist-inspired welfare-state measures and by ignoring the growing popularity of a medically rationalized therapeutic state. Although Creveld’s book runs to 438 pages, he does not mention the war on drugs or the pervasive influence of psychiatric-social controls. Others celebrate the “retreat of the state” (for example, Lawson 2000, Strange 1996, and Swann 1998—each book titled *The Retreat of the State*). I agree with economist Robert J. Samuelson’s observation that the government is “getting bigger because, paradoxically, we think it’s getting

smaller” (2000, 33). That curious outcome is just one of the results of the politicization of medicine and of the medicalization of politics.

Pharmacocracy in America

From 1776 until 1914, when the first antinarcotic legislation was enacted, the federal government played no role in civilian medicine. Medical licensure and the funding and management of state mental hospitals were functions of the state governments. After World War II, the situation changed rapidly and radically: the establishment of the National Institutes of Health, the enactment of Medicare and Medicaid legislation, and the war on drugs soon made medical expenditures the largest component of the national budget, eclipsing defense. The following statistics illustrate the explosive growth of the therapeutic state since the end of World War II and especially since the early 1960s.

- In 1950, funding for the National Institute for Mental Health was less than \$1 million; ten years later, it was \$87 million; in 1992, it reached \$1 billion (“1993 Appropriations” 1992, A-27). In 1965, when Medicare and Medicaid were enacted, their cost was \$65 billion; in 1993, it was nearly \$939 billion (Sharkey 1994, 240). Between 1969 and 1994, the national mental health budget increased from about \$3 billion to \$80 billion (Sharkey 1999). Between 1968 and 1983, the number of clinical psychologists tripled, from 12,000 to more than 40,000; the number of clinical social workers grew from 25,000 in 1970 to 80,000 in 1990; and membership in the American Psychological Association grew from fewer than 3,000 in 1970 to more than 120,000 in 1993 (Nolan 1998, 7–8; see also Hogan 1995).
- Between 1960 and 1996, the total “national health expenditures” share of national product rose about two and a half times, from 5.1 percent of the gross domestic product (GDP) to 13.6 percent, and the share of “federal government expenditures” on health rose more than six times, from 3.3 percent of the GDP to 20.7 percent. In 1995, total health expenditure, as a percentage of the GDP, was 13.6 percent in the United States, 10.4 percent in Germany, 8.6 percent in Australia, and 6.9 percent in the United Kingdom. In health expenditures per capita that year, the United States led all other countries by even bigger margins. The figures were \$3,633 for the United States, \$2,134 for Germany, \$1,741 for Australia, and \$1,246 for the United Kingdom (U.S. Department of Health and Human Services 1998, 341–42).
- Perhaps the most striking statistic is that between 1960 (before Medicare and Medicaid) and 1998, public expenditure on health care per capita increased more than one hundred times, from \$35 to \$3,633 (*ibid.*, 345).

The growth of the state is dramatically and unequivocally illustrated by its cost to the taxpayer, that is, by the federal budget. The following figures are in nominal dollars. In fiscal 1941, before the United States entered World War II, the budget was \$13.6 billion; today, the war on drugs alone costs \$19 billion. In 1942, the budget more than doubled, to \$35.1 billion; then in 1943, it was \$78.5 billion, but it did not reach \$100 billion until 1962. In the next thirty-six years, the budget increased about sixteen times, to \$1.65 trillion in 1998 (*World Almanac*, 108–9). According to James M. Buchanan, “In the seven decades from 1900 to 1970, total government spending in real terms increased forty times over, attaining a share of one-third in national product” (1975, 162).

The explosive expansion of the government after the 1960s is attributable largely to adding civilian medical care to the functions of the state. This transformation of medicine has utterly distorted the relationship between the private and public realms in general, especially the relationship between private health and public health. What makes the explosive expansion of the therapeutic state especially alarming is the widespread belief that the government is niggardly with respect to health care, especially mental health care—a myth largely fueled by the fact that the number of persons housed in buildings called “state mental hospitals” has decreased since the 1960s. I have documented elsewhere that although it is true that fewer people now reside in state hospitals than did thirty years ago, it is an illusion to think that the scope and power of psychiatry have diminished. The number of persons cared for in one way or another by the mental health system has steadily increased since the end of World War II, as have mental health expenditures (Szasz [1994] 1998, esp. 150–86). Despite these facts, the author of a “special report” in the *American Bar Association Journal* declares, “No one disputes that government support for the treatment of mental illness has dropped to dangerously low levels” (Gibeaut 2000).

The Anatomy of Pharmacracy: Secret Censorship as Health Care

The United States is the only country explicitly founded on the principle that in the inevitable contest between the private and public realms, the scope of the former should be wider than that of the latter. That principle is what made America the “land of the free,” especially in the nineteenth century. “There is a balance of power,” writes Bruce D. Porter, “between the state and civil society. This internal balance of power demarcates the line between the public and the private—if a thing is public, it is subject to state authority; if it is private, it is not” (1994, 9, emphasis added). Pharmacrats want to abolish the private realm altogether. “It is the private sphere that is problematic for public health,” declares Dan E. Beauchamp (1999a, 59), seemingly not realizing that the private sphere is none of the business of public health.

It is a truism that people have more liberty in proportion as more aspects of their lives are private. The American people invited the state to take over the management

of their health, and now they are surprised that they have less control not only over the health care they receive but also over other aspects of their lives. Nor is that loss of control the end of the mischief. The more tax monies are spent on health care, the more firmly entrenched becomes the idea in nearly everyone's mind that caring for people's health requires not individual self-control, but political control—that is, control by deception, seduction, and coercion. The state commands vast resources of misinformation (propaganda) and seduction (money and other economic rewards) and has a monopoly of legitimate force (the law and the police).

Censorship of information has long been a tool of totalitarian states, both religious and secular. Such states need not and do not justify the practice by claiming that it serves the best interests of individuals. However, the First Amendment, which guarantees freedom of the press, prohibits the U.S. government from indulging in the despot's passion to deceive people in their own best interest. Not only has the U.S. government violated this prohibition, it has done so secretly and, after the practice was exposed, defended the violation as a valuable weapon in the war on drugs.

Thanks to the sleuthing of the Internet magazine *Salon*, in January 2000 we learned that for the past three years the government had secretly censored many of the major television shows. What made the practice possible was a law requiring broadcast networks “to match the amount of ‘anti-drug’ advertising bought by the federal government with an equal amount of ‘anti-drug’ public-service announcements,” plus the policy that if the “drug-czar’s office approves a TV program’s anti-drug content, the show itself can be credited against the requirement, allowing the network to then substitute full-price advertising for public-service announcements” (Streisand 2000, 26). The arrangement created a temptation for TV executives to augment their revenues by cooperating with the offers of the antidrug censors. “Under the sway of the office of President Clinton’s drug czar, Gen. Barry R. McCaffrey, many of the most popular shows have filled their episodes with anti-drug pitches. . . . McCaffrey never let on that his office had been turned into a full-blown script-review board” (Forbes 2000; see also Frankel 2000). After the scheme was exposed, McCaffrey offered no apologies: “We plead guilty to using every lawful means to save America’s children,” declared his spokesman (Streisand 2000, 26). President Clinton was equally self-righteous: “I think this guy [McCaffrey] is intense and passionate and committed and we’ve got way too many kids using drugs, still” (Morgan 2000). Richard D. Bonnette, president and chief executive of Partnership for a Drug-Free America, lauded the censors: “The major television networks should be applauded for working with the Office of National, Drug Control policy to include anti-drug story-lines in television shows” (Bonnette 2000, A26).

The Vatican’s *Index of Prohibited Books* was a public document that proudly proclaimed the Roman Catholic Church’s struggle against values it considered subversive. In contrast, the clandestine nature of the White House Office of National Drug Control Policy’s tampering with TV scripts is evidence that those responsible for it knew full well that they were subverting America’s values and perhaps its laws as well.

*Private Health Versus Public Health:
Protecting People from Themselves*

In the case of illness, drawing the line between the private and public realms requires careful consideration of many issues. As a first approximation, we may say that we have a “right to be sick”—an aspect of the right to be let alone—provided our illness does not *directly* harm others. We have a “right” to be sick with hay fever because it does not endanger others, but we do not have a right to be sick with infectious tuberculosis because it does endanger others.

Yet even such a seemingly uncontroversial example as hay fever oversimplifies the matter. To alleviate symptoms, the person suffering from hay fever may ingest antihistamines that, in turn, may render him just as impaired to drive an automobile as would intoxication with alcohol. In fact, simply being a young adult or an old adult makes the person, statistically, a dangerous driver. What constitutes a danger to the public depends in part on what people perceive as a risk—a perception shaped by subjective judgment rather than by statistical probability—and in part on whether people perceive a particular risk as under their own control. Regardless of the statistical risk, people do not worry much about risks they believe they can control.

To complicate matters, the sickness of persons and the sickness of populations represent very different problems for patients, physicians, and politicians. Private health measures that benefit the individual may help or harm the community. Public-health measures that benefit the community may help or harm the individual. The potential conflict between private health and public health is an integral part of the tension between civil society and the state. In his article “Sick Individuals and Sick Populations,” epidemiologist Geoffrey Rose notes that “a preventive measure which brings much benefit to the population offers little to each participating individual. This has been the history of public health—immunization, the wearing of seatbelts, and now the attempt to change various lifestyle characteristics. Of enormous potential importance to the population as a whole, these measures offer very little—particularly in the short term—to each individual” ([1985] 1999, 36–37).

Dealing with health care as a public good raises certain questions, such as: Can we create an insurance system that makes every treatment deemed useful or necessary by a physician also affordable by and available to every member of the community? How can we calculate the cost of health insurance if medical science and technology create and people clamor for ever more expensive treatments? If people take good care of their health and live longer, what cost do they impose on those who pay their pensions or other old-age benefits? If the community pays for the treatment of those who fall ill, doesn’t it inevitably acquire a claim on its members to try as hard as they can not to fall ill? Doesn’t the community also acquire an interest in identifying and penalizing those who frivolously neglect their health or deliberately make themselves ill?

If we assume that people truly value their health, why don't we expect them to be willing to spend at least as much on medical care as they do on drinking, smoking, gambling, entertainment, and veterinary care for their pets? If some people do not value their own health, then it is a folly twice over for the taxpayer to pay for their health insurance. In other words, why don't we subject health-care coverage funded by tax monies to a means test? And why don't we model health insurance on private casualty insurance with a substantial deductibility clause—the insured being responsible for his own health care up to, say, 10 percent of taxable income, before becoming eligible for reimbursement? Indeed, shouldn't we try to return to the situation in which medical care was available mainly to those who were able and willing to pay for it, with care for those who could not pay being distributed on some other basis?

These are difficult questions that most people and all politicians prefer to avoid. Instead, politicians pander to the public with slogans that promise health-care benefits without health-care responsibilities, and people like that pandering. However, with the increasing cost of health insurance and the mounting dissatisfaction of both patients and doctors with mandated "insurance" schemes for health-care coverage, we ought to confront rather than shirk these questions. The truth is that before the federal government went into the business of health care, poor people received free medical services, often of very good quality, at municipal and teaching hospitals. It is doubtful that they receive better care now, but those who can pay often receive worse care than they did formerly. (The terms *better* and *worse* refer here to the human, not the technical, quality of the service.) Moreover, physicians are far less proud of or satisfied with being physicians than they were fifty years ago.

The advocates of pharmacratic politics threaten liberty because they obscure or even deny the differences between the kinds of risks posed by a public water supply contaminated with cholera bacilli and the risks posed by a private lifestyle that includes the recreational use of a prohibited psychoactive drug. Individuals cannot *by an act of will* provide themselves with a safe public water supply, but they can *by an act of will* protect themselves from the hazards of smoking marijuana. What makes coercive health measures justified is not so much that they protect everyone equally, but that they do so by means not available to the individual. By the same token, what makes coercive health measures unjustified is not only that they do not protect everyone equally, but that they replace personally assumed self-protection by self-control with legal sanctions difficult or impossible to enforce. The rhetoric of categorizing certain groups—typically children or the residents of neglected neighborhoods—as "at risk" needs to be mentioned here. The term implies that the persons in question lack self-control and hence need the help of the government to protect them from certain kinds of temptations. Health statisticians on both the left and the right agree.

Gerald Dworkin, for example, believes that "A man may know the facts [about the dangers of smoking], wish to stop, but not have the requisite willpower. . . . In [such a case] there is no theoretical problem. We are not imposing a good on some-

one who rejects it. *We are simply using coercion to enable people to carry out their own goals*” ([1972] 1999, 127–28). This notion is coercive paternalism in pure culture. I maintain that the only means we possess for ascertaining that a man wants to stop smoking more than he wants to enjoy smoking is by observing whether he stops or continues to smoke. Moreover, it is irresponsible for moral theorists to ignore that coercive sanctions aimed at protecting people from themselves are not only unenforceable but create black markets and horrifying legal abuses.

The idea that the state has a duty to protect people from themselves is an integral part of the authoritarian, religious-paternalistic outlook on life—now favored by many atheists as well. Once people agree that they have identified the one true God, or Good, it follows that they must guard members of the group, and nonmembers as well, from the temptation to worship false gods or goods. The post-Enlightenment version of this view arose from a secularization of God and the medicalization of good. Once people agree that they have identified the one true reason, it follows that they must guard against the temptation to worship unreason—that is, madness.

Confronted with the problem of “madness,” Western individualism was ill prepared to defend the rights of the individual: modern man has no more right to be a madman than medieval man had a right to be a heretic. In the seventeenth century, when madness appeared in its modern guise, the problem it presented resembled not only the problem of heresy but also the problem of disease, especially of the brain. Madness was perceived as an illness of the mind, caused by a hypothesized disease of the brain, an image that invited the conflation of risk to the public with risk to the self—hence the view of the insane person as “dangerous to himself or others.” For centuries, this verbal formula has justified involuntary mental hospitalization. There is a large literature on this subject, to which I have contributed my share, and I shall say no more about it here. Instead, I shall limit the discussion to a few remarks about medical-legal coercion whose avowed aim is to protect *mentally healthy* people from themselves.

Aside from suicide, whose legal-political status is obscured by its being authoritatively attributed to mental illness, a classic contemporary example of potentially self-injurious behavior is riding a motorcycle without a helmet (Germer 2000). (That riding a motorcycle *with* a helmet is also dangerous is beside the point here.) How do courts interpret the constitutionality of prohibiting people from riding a motorcycle without a helmet? Can helmet laws be justified by invoking the police power inherent in the sovereignty of states, enabling the legislatures “to act for the protection of the public health, safety, morals, and general welfare” (Stone 1969, 112), even though such laws are silent about protecting people from themselves? Some authorities say yes, some say no; the answer depends on whether the observer regards the subject’s behavior as a private matter that affects only him or as a public matter that affects others as well. One court “held the statute to be an unconstitutional exercise of the police power,” citing the following legal maxims: “The individual is not accountable for his actions, insofar as

these concern the interest of no person but himself” and “So use your own that you do not harm that of another” (Stone 1969, 113–14). Another court held that the state has an interest in having robust, healthy citizens and, therefore, “the statute forcing an individual to protect himself falls within the scope of the police power” (114).

The issue comes down to *whether the individual is viewed as a private person or as public property*: the former has no obligation to the community to be or stay healthy; the latter does. In proportion as medical care is provided by the state, doctors and patients alike cease to be private persons and forfeit their “rights” against the opposing interests of the state. Declares Alan I. Leshner, head of the National Institute of Drug Abuse (NIDA): “My belief is that today, in 1998, you [the physician] should be put in jail if you refuse to prescribe S.S.R.I.s [Selective Serotonin Reuptake Inhibitors, a type of so-called antidepressant medication] for depression. I also believe that five years from now you should be put in jail if you don’t give crack addicts the medication we’re working on now” (qtd. in Samuels 1998, 48–49). In plain English, Leshner dreams of *coercing physicians to drug patients forcibly*.

History teaches us that we ought to be cautious about embracing professional protectors as our guardians: they often demean, coerce, and injure their beneficiaries and do their best to render them abjectly dependent on their tormentors. Transforming the United States from a constitutional republic into a therapeutic state has shifted the internal balance of power in favor of the government and against the individual. Ironically, this shift has been accompanied by widespread complaints by the cognoscenti about a surfeit of autonomy plaguing Americans (Gaylin and Jennings 1996). They mistake for autonomy what is in fact selfishness engendered by the growth of pharmacratic regulations and the therapeutic state. (I use the term *pharmacratic regulations* to refer to controls exercised by bureaucratic health-care regulations and enforced by health-care personnel, such as alcohol treatment and other addiction programs, school psychology, suicide prevention, and the mandatory reporting of personal [mis]behavior as part of the duties of pediatricians, internists, psychiatrists, and other health-care personnel.)

Coercion as Treatment: Justifying Pharmacracy

Coercion masquerading as medical treatment is the bedrock of political medicine. Long before the Nazis rose to power, physician-eugenicists advocated killing certain ill or disabled persons as a form of treatment for both patient and society. What transforms coercion into therapy? Physicians *diagnosing* the subject’s condition a “disease,” *declaring* the intervention they impose on the victim a “treatment,” and legislators and judges *ratifying these categorizations* as “diseases” and “treatments.” Simply put, the pharmacrat’s stock-in-trade is denying the differences between the medical care that patients seek and the “treatments” imposed on them against their will—in short, defining violence as beneficence.

The normal applications of the criminal law tell us that the difference between depriving a person of his liberty and depriving him of his life is a matter of degree, not kind. The history of religious persecution teaches the same lesson more dramatically. Medical ethicists and psychiatrists ignore this evidence: they embrace medicalized deprivation of liberty, provided it is called “hospitalization,” “outpatient commitment,” “drug treatment,” and so forth. Many of them approve even deprivations of life, provided it is called “physician-assisted suicide” or “euthanasia.” Let me restate the elements necessary to qualify a medical *intervention* as a medical *treatment*. From a scientific point of view, an intervention counts as treatment only if its aim is to remedy a true disease; the identity of the person doing the remedying does not matter: self-medication with an analgesic for pain or with an antihistamine for hay fever counts as treatment. From a legal point of view, an intervention counts as treatment only if it is performed by a physician licensed to practice medicine, with the consent of the subject or his guardian; disease, diagnosis, and medical benefit are irrelevant. Consensual treatment is treatment only if the patient has a true disease, regardless of whether that treatment is effective or does more harm than good. Nonconsensual “treatment” is assault, even if it cures the patient of his disease.

The Perversion of Medicine: Disease as “Treatability”

“When meditating over a disease,” wrote Louis Pasteur, “I never think of finding a remedy for it” (qtd. in Dubos 1950, 307). When the pharmacrat meditates over disease, he thinks of nothing but how to remedy it; and because he views benevolent coercion as treatment, he discovers diseases where his patient/victim sees only behaviors that the pharmacrat wants to change or punish.

The idea of defining disease in terms of treatability is not new. The prescientific physician and his clients often perceived illness that way. The principal difference between the old-fashioned quackery of, say, Mesmer, and the newfangled quackery of, say, our Surgeons General, is that Mesmeric “treatments” were never imposed on persons against their will, whereas the “treatments” endorsed by the Surgeons General often are.

Nazi pharmacracry was based on the premise that the Jew was a cancer on the body politic of the Reich; it had to be removed at any cost. American pharmacracry is based on the premise that the individual with a dangerous disease, epitomized by the drug abuser, is a threat to the well-being of the nation; he has to be cured at any cost. In a brief article in the *Journal of the American Medical Association (JAMA)*, A. I. Leshner repeats this theme three times: “There are now extensive data showing that addiction is eminently treatable”; “addiction is a treatable disease”; and “overall, treatment of addiction is as successful as treatment of other chronic diseases, such as diabetes, hypertension, and asthma” (1999, 1314–16). Leshner studiously refrains from acknowledging that “treatment” for “addiction” is typically imposed on the subject by force.

Sally Satel, a psychiatrist at Yale University, is more forthright. “As a psychiatrist who treats addicts,” she writes in a 1998 op-ed essay in the *Wall Street Journal*, “I have learned that legal sanctions—either imposed or threatened—may provide the leverage needed to keep them alive by keeping them in treatment. Voluntary help is often not enough” (6). The essay is titled “For Addicts, Force Is the Best Medicine.” It does not bode well for liberty that even the editors of the *Wall Street Journal* apparently agree.

The proposition that the use of illegal drugs is a brain disease poses problems of its own. Brain diseases cannot be treated without the patient’s consent. How, then, do Leshner, Satel, and others justify using force to treat *this* brain disease but not others? Satel declares, “Addicts would be better off if more of them were arrested and forced to enroll in treatment programs. . . . [This is] the essence of humane therapy” (1998, 6). The truth is that persons with real brain diseases need not be coerced into treatment because they can be persuaded to accept it. Is it any surprise that coercion is necessary to treat nondiseases?

In June 2000, Judith S. Kaye, chief judge of the state of New York, announced that “[New York] State courts will start using their ‘coercive’ powers immediately to get nonviolent drug offenders into treatment programs” (Finkelstein 2000). Although defendants are under duress to accept “treatment,” the therapists maintain that “accepting treatment is ultimately *voluntary*. . . . To be eligible, offenders will have to be . . . *willing to plead guilty*. . . . Even if a defendant chooses to stand trial, the judges and district attorneys will still have the discretion to refer them to drug treatment until trial. *If they are found not guilty, in all likelihood treatment will be continued*,” said a court spokesman. . . . If they relapse, they will go to jail, most likely receiving stiffer sentences than normally given now” (“Plan for Nonviolent Addicts Coming” 2000, emphasis added). This example shows what happens to the concepts of disease, treatment, and voluntariness when politicians define illness and treatment.

Judge Kaye is proud of what she calls her “hands-on court” that promotes “problem solving.” The problem she has in mind is how to get people to stop doing what they like to do—in this case, using illegal drugs. What makes Judge Kaye think that the drug-treatment sentences she imposes solve drug problems? “We know,” she writes, “that a defendant in a court-ordered drug treatment is twice as likely to complete the program as someone who gets help voluntarily” (1999, 13). The fact that drug prisoners complete court-ordered “programs” proves that they want to be free of meddling judges, not that they are free of the desire to take drugs. Moreover, completing a “drug-treatment program” means simply being present at required meetings; it does not entail acquiring new knowledge or skills, as does completing an academic program. The result of Judge Kaye’s sentence is exactly the opposite of what happens in a genuine educational program: it is unlikely that a person participating in such a program against his will would complete it, but it is likely a person who participates voluntarily (and pays for it) would do so.

Stories of judges practicing therapeutic jurisprudence abound in the media (see “Fat Man Is Told” 1995, “Internet-Addicted Mom” 1998). In Dade County, Florida, persons “caught using or purchasing drugs are considered ‘clients’ or ‘members’ rather than ‘offenders’ or ‘defendants.’ . . . [I]nstead of trying to prosecute the defendant, the district attorney becomes part of the Drug Court team trying to help the defendant toward recovery” (Nolan 1998, 99, 97). A judge in Florida uses the phrase “‘therapeutic jurisprudence’ to describe the court’s role as a facilitator of the healing process. . . . ‘This is a helping court . . . which *defendants enter voluntarily*’” (“MH Courts” 1999, 10, emphasis added; see also Christian 1999, A13). Sadly, we have no Swifts, Menckens, or Orwells warning people against Gulliverian tales of court-coerced habit retraining portrayed as “voluntary treatment” or of courtrooms characterized as places that “defendants enter voluntarily.”

Leading physicians fuel the propaganda for therapeutic coercions as remedies for social problems. In 1992, Surgeon General C. Everett Koop and *JAMA* editor-in-chief George D. Lundberg declared, “One million US inhabitants die prematurely each year as a result of intentional homicide or suicide. . . . We believe violence in America to be a public health emergency” (Koop and Lundberg 1992, 3076). Being murdered and dying voluntarily are here treated as similar phenomena, and both are categorized as preventable diseases posing a “public health emergency.” Articles about smoking, violence, and war are staples in the pages of *JAMA*. Some typical titles: “Tobacco Dependence Curriculum in US Undergraduate Medical Education” (Ferry, Grissino, and Runfola 1999); “The Medical Costs of Gunshot Injuries in the United States” (Cook et al. 1999); “The Future of Firearm Violence Prevention” (Wintemute 1999); “War and Health: From Solferino to Kosovo” (Iacopino and Waldman 1999); and “What Can We Do about Violence?” (Cole and Flanagan 1999).

In Great Britain, too, the medical establishment is solidifying its marriage to the state. In July 1999, the British Medical Association proposed that in order to increase “the number of donated organs, everyone should be assumed to be a donor unless they opted out” (Phillips 1999). With body ownership vested in the state, it is reasonable that the state should decide what counts as disease and treatment. In July 1999, a three-judge Court of Appeals in Britain ruled that the National Health Service (NHS) “wrongly regarded transsexualism as a state of mind that did not warrant medical treatment rather than as an illness. . . . [The judges ordered the NHS to] provide sex-change operations for transsexuals because they suffer from a *legitimate illness*. . . . About 1,000 transsexuals . . . will be entitled to the \$13,000 sex-change surgery free of charge” (qtd. in “Notable & Quotable” 1999, A14). According to the judges, sex-change operation is “*the proper treatment of a recognized illness*” (qtd. in MacCarthy 1999, 19, emphasis added). Recognized by whom? The bureaucrats of the therapeutic state.

In September 1999, the *Sunday Times* (London) reported that “The government is considering proposals to appoint secular ‘vicars,’ paid for by the state, to give

pastoral care to families . . . offering pastoral advice and urging parents who do not attend church to put their children through a ‘civil naming ceremony’” (Bevan and Prescott 1998). Evidently in vain did Daniel Defoe (1660–1731) warn, “Of all plagues with which mankind are cursd, / Ecclesiastic tyranny’s the worst” (*The Oxford Dictionary of Quotations*, 234). Secularism may protect us from the dangers of theological tyranny, but it does not protect us from the dangers of therapeutic tyranny. Electing a national leader by a majority of the people’s votes may protect us from being ruled by an aristocracy, but it does not protect us from being ruled by a pharmacocracy.

Medical Ideology, Public Health, and Socialism

Before considering the connections between medicine and the state in National Socialist Germany, it may be instructive to review briefly the connections among antipoverty policies, public-health measures, and the state.

Health, Poverty, and the State

For centuries, the relief of both poverty and illness, especially illness affecting the poor, was the responsibility of the church. “It is interesting to notice,” wrote socialist dreamers Sidney and Beatrice Webb in 1910, “that the Public Health medical service and the Poor Law medical service sprang historically from the same source, namely the prevalence of disease among the pauper class, and the economy of diminishing it” (Webb and Webb 1910, 1). In the modern world, the state assumes both functions. Since World War II, the relief of illness has increasingly been perceived as a duty the state owes all its citizens.

The state’s subvention of medical care creates many problems, as we have seen already. Becoming ill and recovering from illness have a great deal to do with motivation, personal habits, and self-discipline. The Webbs, though ardent lovers of Leviathan, recognized this fact and warned against it, anticipating the criticisms of Ludwig von Mises, the ardent enemy of Leviathan. “The very humanity and professional excellence of the Poor Law infirmary,” the Webbs explained, “*constitute elements in the breaking down of personal character and integrity, and may even be said actually to subsidize licentiousness, feeble-mindedness, and disease*” (1910, 238, emphasis added). To prevent the cure from being worse than the disease, the Webbs proposed that “the curative treatment of individual patients by the Public Health Service . . . [be accompanied by] a *constant stream of moral suasion, and when necessary, disciplinary supervision*, to promote physical self-restraint and the due care of offspring” (239, emphasis added).

In the Soviet Union, the socialization of the economy led to widespread economic dissatisfaction. In Western democracies, the socialization of medicine is now leading to a similar widespread dissatisfaction with medicine, among patients and

physicians alike. Because the interests of the state as producer of goods or provider of medical services are not the same as the interests of people as consumers or patients, this result is hardly surprisingly.

Health and the National Socialist State

Hitler recognized that the direct takeover of private property provokes powerful emotional and political resistance. One of the secrets of his rise to power was that he managed to portray the National Socialist movement as opposed to such a measure, indeed as opposed to communism itself. As Robert Proctor notes, Hitler understood that there was no need to “nationalize industry when you can nationalize the people” (1999, 74). I want to emphasize here that I regard “right-wing” Nazism and “left-wing” communism not as two antagonistic political systems, but as two similar types of socialism (statism)—one brown or national, the other red or international. Both kinds of statist were very successful in their efforts to undermine autonomy and to destroy morality.

The therapeutic state as a type of total state with a sacred and therefore unopposable mission is not a new historical phenomenon. The theological state, the Soviet state, and the Nazi state may be viewed as former incarnations of it (see Szasz [1970] 1997 and 1984, esp. 213–38; and Bloch and Reddaway 1977). To illustrate and underscore the problems intrinsic to the alliance between modern medicine and the modern state, I shall briefly review the anatomy of National Socialist Germany as a type of therapeutic state.

From the beginning of his political career, Hitler couched his struggle against “enemies of the state” in medical rhetoric. In 1934, addressing the Reichstag, he boasted, “I gave the order . . . to burn out down to the raw flesh the ulcers of our internal well-poisoning” (qtd. in Kershaw 1999, 494). National Socialist politicians and the entire German nation learned to speak and think in such terms. Werner Best, Reinhard Heydrich’s deputy, declared that the task of the police was “to root out all symptoms of disease and germs of destruction that threatened the political health of the nation. . . . [In addition to Jews,] most [of the germs] were weak, unpopular and marginalized groups, such as gypsies, homosexuals, beggars, ‘antisocials,’ ‘work-shy,’ and ‘habitual criminals’” (qtd. in *ibid.*, 541).

None of this was a Nazi invention. The use of medical metaphors to justify the exclusion and destruction of unwanted persons and groups both antedates Hitler’s rise to power and flourishes today. In 1895, a member of the Reichstag called Jews “cholera bacilli” (Gilman 1993, 435). In 1967, Susan Sontag, the celebrated feminist-liberal writer, declared, “The truth is that Mozart, Pascal, Boolean algebra, Shakespeare, parliamentary government, baroque churches, Newton, the emancipation of women, Kant, Marx, Balanchine ballets, *et al.*, don’t redeem what this particular civilization has wrought upon the world. *The white race is the cancer of human history*; it is the white race and it alone—its ideologies and inventions—which eradicates

autonomous civilizations wherever it spreads, which has upset the ecological balance of the planet, which now threatens the very existence of life itself" (57–58).

Despite all the evidence, the political implications of the therapeutic character of Nazism and of the use of medical metaphors in modern democracies remain underappreciated or, more often, ignored. It is a touchy subject not because the story makes psychiatrists in Nazi Germany look bad. That practice has been dismissed as an "abuse of psychiatry." Rather, it is a touchy subject because it highlights the dramatic similarities between pharmacratic controls in Germany under National Socialism and those in the United States under what is euphemistically called the "free market."

Nazi Pharmacracry: I. Socialist Health Care

The definitive work on pharmacracry in Nazi Germany is *Health, Race, and German Politics between National Unification and Nazism, 1870–1945* by Paul Weindling, a scholar at the Wellcome Institute for the History of Medicine in London. Unlike many students of the Holocaust, Weindling does not shy away from noting the similarities between the medicalization of politics and the politicization of health both in Nazi Germany and in the West. Many of Weindling's observations and comments about Nazi Germany as a therapeutic state (a term he does not use) sound as if they made reference to conditions in the United States today. He writes:

Scientifically-educated experts acquired a directing role as prescribers of social policies and personal lifestyle. . . . science and medicine provided an alternative to party politics, by forming a basis for collective social policies to remedy social ills. (1998, 1)

The sense of responsibility of the doctor to sick individuals weakened as awareness dawned of the economic costs of poverty and disease. . . . Medicine was transformed from a free profession . . . to the doctor carrying out duties of state officials in the interests not of the individual patient but of society and of future generations. . . . Doctors became a part of a growing state apparatus. (2, 6)

Weindling retraces the political-economic history of modern medicine, reminding us that "In 1868 medicine was proclaimed a 'free trade,' open to all to practice. . . . without legal penalties against quackery. . . . Leaders of the profession such as Rudolf Virchow were convinced that scientific excellence guaranteed the future of the profession" (14). *That* was a free market in medicine. Today, in contrast, the state stringently regulates trade in medical goods and services.

Long before Hitler rose to power, observes Weindling, physicians "sought to colonize new areas for medicine, such as sexuality, mental illness, and deviant social behaviour. What had been private or moral spheres were subjugated to a hereditarian social

pathology. . . . As the medical categories invaded the terrain of social categories, the greater became the potential for creating a society corresponding to a total institution” (7, 19). Deception and self-deception by medical rhetoric were popular as far back as 1914, when German military service was glorified “as healthier than urban life. The fresh air and exercise of the front meant that it could be a vast open air sanatorium. Another indicator of health was the fall in the number of mental patients and a decrease of suicides” (283). Indeed, war is the political health of the state and the mental health of the individual.

Bedazzled by the myth of mental illness and seduced by psychiatry’s usefulness for disposing of unwanted persons, the modern mind recoils from confronting the irreconcilable conflict between the political ideals of a free society and the coercive practices of psychiatry. Let us keep in mind that psychiatry began as a statist enterprise: the insane asylum was a public institution, supported by the state and operated by employees of the state. The main impetus for converting private health into public health came and continues to come from psychiatrists.

In 1933, the year Hitler assumed power, a law was passed against “compulsive criminality . . . enabling preventive detention and castration. . . . [for] schizophrenia, manic-depression, [etc.]. . . . The medical profession and especially psychiatrists benefited greatly from the drive for sterilization” (Weindling 1989, 525). Reich Health Leader (*Reichsgesundheitsführer*) Leonardo Conti (1900–1945) stated that “no one had the right to regard health as a personal private matter, which could be disposed of according to individualistic preference. Therapy had to be administered in the interests of the race and society rather than of the sick individual” (518).

In 1939, medical killing in Germany went into high gear. “Reliable helpers were recruited from the ranks of psychiatrists,” who defined lying for the state as a higher form of morality: “Each euthanasia institution had a registry office to issue the false [death] certificates” (Weindling 1989, 544, 549). In the case of tuberculosis, modern diagnostic technology was employed as a tool for determining who qualified for therapeutic killing: “In occupied Poland and the Soviet Union, SS X-ray units sought out the tubercular, who were then shot. It is estimated that 100,000 died in this way” (550).

The more power physicians exercised, the more intoxicated with power they became. “The doctor was to be a Führer of the *Volk* to better personal and racial health. . . . Terms like ‘euthanasia’ and ‘the incurable’ were a euphemistic medicalized camouflage with connotations of relief of the individual suffering of the terminally ill” (Weindling 1989, 576–77, 542–43). Amidst all the carnage, the Nazis remained obsessed with health: “A plantation for herbal medicines was established at the Dachau concentration camp” (537).

Nazi Pharmacracy: II. Waging War for Health

In *The Nazi War on Cancer*, Robert N. Proctor, professor of history at Pennsylvania State University, remarks on the similarities between pharmacratic controls in Nazi

Germany and those in the United States today, only to dismiss those similarities as irrelevant. “My intention,” writes Proctor, “is not to argue that today’s antitobacco efforts have fascist roots, or that public health measures are in principle totalitarian—as some libertarians seem to want us to believe” (1999, 277). Proctor’s systematic labeling of Nazi health measures as “fascist” is as misleading as it is politically correct. Hitler was not a fascist, and National Socialism was not a fascist movement. It was a socialist movement wrapped in the flag of nationalism. The terms *fascist* and *fascism* belong to Mussolini and his movement and to Franco and his movement, neither of which exhibited the kind of interest in health or genocide exhibited by Hitler and the Nazis.

Proctor steers clear of discussing psychiatric practices in Nazi Germany, such as the following typical episode, even though they closely resemble psychiatric practices in the United States today. A father, a retired philologist, complains about the sudden death of his physically healthy schizophrenic son, Hans. He writes to the head of the institution where Hans had been confined, complaining that the explanation for his death was “contrary to the truth” and that “this affair appears to be rather murky.” The psychiatrist replies: “The content of your letter . . . forces me to consider psychiatric measures against you. . . . should you continue to harass us with further communications, I shall be forced to have you examined by a public health physician” (qtd. in Friedlander 1995, 180–81). Although Proctor’s apologetics for pharmacracy in America diminishes the intellectual significance of his work, it does not impair the value of his documentation.

As Proctor himself shows, it was principally psychiatry that provided the “scientific” justification and personnel for medical mass murder in Nazi Germany. Nevertheless, he declares, “I should reassure the reader that I have no desire to efface the brute and simple facts—the complicity in crime or the sinister stupidities of Nazi ideology” (1999, 252). To call Nazi ideology “stupid” is like calling a distasteful religious belief “stupid.” It is a self-righteous refusal to understand the Other’s ideology on its own terms, as if understanding it were tantamount to approving it. The truth is that the Nazi health ideology closely resembles the American health ideology. Each rests on the same premises—that the individual is incompetent to protect himself from himself and needs the protection of the paternalistic state, thus turning private health into public health. Proctor is too eager to efface the method in the madness of the Nazis’ *furor therapeuticus politicus*, perhaps because it is so alarmingly relevant to our version of it.

“Nazism itself,” he writes, “I will be treating as . . . a vast hygienic experiment designed to bring about an exclusionist sanitary utopia. That sanitary utopia was a vision not unconnected with *fascism’s* [*sic*] more familiar genocidal aspects” (Proctor 1999, 11, emphasis added). It was not fascism, which was not genocidal, but medical puritanism that motivated the Nazis to wage therapeutic wars against cancer and Jews. This is a crucial point. Once we begin to worship health as an all-pervasive good—a moral value that trumps all others, especially liberty—it becomes sanctified as a kind of secular holiness.

With respect to the relationship between health and the state, Hitler's basic goal was the same as Plato's, Aristotle's, and the modern public-health zealots'—namely, abolishing the boundary between private and public health. Here are some striking examples, all of which Proctor misleadingly interprets as manifestations of “fascism”:

- Your body belongs to the nation! Your body belongs to the Führer! You have the duty to be healthy! Food is not a private matter! (National Socialist slogans) (1999, 120)
- We have the duty, if necessary, to die for the Fatherland; why should we not also have the duty to be healthy? Has the Führer not explicitly demanded this? (Anti-tobacco activist, 1939) (58)
- Nicotine damages not just the individual but the population as a whole. (Anti-tobacco activist, 1940) (26)

Hitler and his entourage were health fanatics obsessed with cleanliness and with killing “bugs,” the latter category including unwanted people, especially Jews, Gypsies, homosexuals, and mental patients. Hitler neither drank nor smoked and was a vegetarian. Preoccupied with the fear of illness and the welfare of animals, he could not “tolerate the idea of animals’ being killed for human consumption” (Proctor 1999, 136). After Hitler became chancellor, Reichsmarshal Hermann Goring announced an end to the “unbearable torture and suffering in animal experiments.” The medical mass murder of mental patients went hand in hand with the prohibition of vivisection, which was declared a capital offense (129; see also Borkin [1978] 1997, 58). The fact that the Nazi public-health ethic demanded not only respect for the health of the greatest numbers (of Aryans) but also for the health of animals (except “bugs”) illustrates the connections between the love of pharmacracy and animal rights, on one hand, and the loathing of human rights and the lives of imperfect persons, on the other hand. (The work of bioethicist Peter Singer (1994) also illustrates these connections; see also “Dangerous Words” 2000 and Szasz 1999, 89, 96–97.)

Instead of viewing the Nazi experience with medicalized politics as a cautionary tale illuminating the dangers lurking in the alliance between medicine and the state, Proctor uses it to speculate about what the Nazi war on cancer “tells us about the nature of *fascism*” (1999, 249). He arrives at the comforting conclusion that “the Nazi analogy is pretty marginal to contemporary discussions about euthanasia and criticizes “pro-tobacco activists”—as if opposing antitobacco legislation made one automatically a “pro-tobacco activist”—who “play the Nazi card” (271). Our future liberty, and health as well, may depend on whether we dismiss the analogy between pharmacracy in Nazi Germany and pharmacracy in contemporary America as “pretty marginal,” as Proctor believes we should, or whether, as I suggest, we view it as terrifyingly relevant and treat it with utmost seriousness.

Medicalizing “Psychological Trauma”

To future students of U.S. history, 1999 may seem to have been a peaceful year. But the medicalizers of life did not see it that way. “The world as we approach the millennium,” intones a physician in *JAMA*, “is full of horrific events, in addition to warfare, that can lead to post-traumatic stress disorder (PTSD). Survivors of natural disasters and life-threatening violence, including recent attacks at schools, religious centers, and other venues not normally associated with bloodshed in the United States, may develop PTSD, *particularly if they do not receive immediate mental health care*” (Jefferson 1999).

Because the diagnosis of PTSD rests on the concept of trauma, we must be clear about what we mean when we use that term. *Webster’s* primary definition of *trauma* is “an injury or wound to a living *body* caused by the application of *external force or violence*” (emphasis added). The diagnosis of PTSD, like that of mental illness itself, thus rests on metaphorizing the word “trauma,” changing its meaning from physical injury to the body to psychological injury to the mind. Making the diagnosis does not require that the subject suffer an actual injury. Having *witnessed* a “traumatic situation” is enough. Every such witness is presumed to suffer from or to be a candidate for PTSD unless he receives prompt mental health care *to prevent it*.

PTSD is now routinely *imputed* to people, especially to children helpless to reject the label. A child is murdered or kills himself. Instantly, his classmates—perhaps all of the children in the school—become patient fodder for “grief counselors,” who are forcibly imposed on them by the health-care commissars of the therapeutic state (Labi 1999; Seligman 2000; Toolis 1999). Adults, too, are treated as if they could not manage their own grief unassisted by helpers they do not seek. A plane crashes. Relatives and friends of the victims are met by “grief counselors.” What in the past Americans would have considered ugly meddling, they now accept as medically sound mental health care.

Madison was right when he warned his fellow Americans that of all the enemies to public liberty, war is “the most to be dreaded, because it . . . is the parent of armies.” However, perhaps because he was so secure in being an adult, he ignored the infantilism that often clings to people throughout life, manifested by their love of soldiering and their adoration of military heroes. Socialist leaders love soldiers, and the socialist masses love soldiering for those leaders: “The Nazi state declared civil servants to be ‘administrative soldiers,’ school teachers ‘soldiers of education,’ doctors ‘soldiers of medicine’” (Porter 1994, 200). Soviet propaganda employed similar images. The American therapeutic state also loves soldiers—waging wars against diseases, drugs, and other “social problems,” such as teenage pregnancy, suicide, violence, and war itself. Literal soldiers, sent abroad by the government, are “peacekeepers” where there is no peace and “liberators” where the term *liberty* means the opportunity to persecute and kill your adversary. Metaphorical soldiers, often led by

arrogant and ignorant First Ladies, are people whose mantra W. H. Auden aptly satirized: “We are all here on earth to help others; what on earth the others are here for, I don’t know” ([1962] 1968, 14).

In the United States today, the passion to judge, condemn, stigmatize, and denounce others often masquerades as “helping.” From elementary school onward, children are indoctrinated to report the “misbehavior” of siblings and parents at home and fellow students at school. This indoctrination, presented as health education, never ceases; for adults, it is peddled as suicide prevention, drug-abuse prevention, and the promotion of mental health—the emblems of good citizenship in the therapeutic state. The view that certain disapproved or disliked behaviors are not necessarily “problems” and might not be the business of others is considered heresy. The individual as informant—“helping” others with their “health problems”—has become our ideal of the “responsible” person and model citizen. The fact that many such persons are unwilling or unable to assume responsibility for their own behavior only enhances the model citizen’s image.

It takes a lot of helpless people to keep all the helpers happy, and the helpers, thanks to their diligence and army of informants, are never at a loss to find people who are in dire need of their help. In such circumstances, the medicalization of everyday life becomes useful. Most people have come to accept that bad deeds are attributable to diseases and hence the doer is blameless, whereas good deeds spring from free will and hence the doer deserves credit for them.

Post-traumatic Stress Disorder

The *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* defines PTSD as a set of distressing feelings that follow “witnessing an event that involves death, injury, or other threat to the physical integrity of another person, or learning about unexpected or violent death, serious harm, or threat of death or injury by a family member or other close associate” (424). By this definition, the entire population of Europe between 1939 and 1945 was the victim of undiagnosed and untreated PTSD.

James M. Turnbull, a professor of family medicine at East Tennessee State University, warns physicians to be on the alert for PTSD among “battered women and men, adult children of alcoholics, police officers and firefighters, medical personnel who deal directly with trauma victims, noncombatants in war-torn areas such as—to choose just two recent ones—Kosovo and East Timor, and occasionally even spouses and children of persons with PTSD” (qtd. in Jefferson 1999). The mere act of living with someone with PTSD is here construed as a risk for contracting it. For good measure, Turnbull reembraces the traditional religious view of suicide as murder: “Grief following the suicide of a friend or relative presents a special case of emotional trauma . . . A survivor’s reaction during this time almost always includes . . . anger at the dead person, who is not only the victim but also the *killer* of the survivor’s loved one” (emphasis added).

To the psychiatrically enlightened, anything connected with death is now a symptom of mental illness: thinking about death is “suicidal ideation”; wanting to die is “being a suicidal risk”; witnessing death is “PTSD.” Because death is an integral part of life, the medicalization of death goes a long way toward creating an endless supply of patients in need of help. In the past, attending a funeral was a somber social custom, honoring the deceased and his relatives. Today, especially if the deceased is displayed in an open casket, it is “witnessing an event that involves death,” hence a pathogen causing PTSD. A movie reviewer remarks: “In past ages, Joan [of Arc] has been seen as a mystic, a saint, a national hero. Now, in keeping with the times, she is a victim of post-traumatic stress disorder” (Acocella 1999, 98).

Because mental patients often kill themselves, psychiatric residents are especially prone to become victims of PTSD: twenty percent report symptoms of it after patient suicide. “My first reaction,” says [Cindy] Grief [*sic*], after one of her patients killed herself, “was to tell myself that she had a disease like cancer and that it was her illness that caused her death.” Although that notion is part of the psychiatric catechism she was taught, it did not help: soon she was named in a lawsuit brought by the family (“Residents Need” 1999, 24). Psychiatric residents are upset after a patient’s suicide because they are not taught that killing oneself is a basic human right and incarcerating people in mental hospitals is a grave moral wrong; and that, although the suicide is not their fault (because it is not in their power to prevent it), when a mental patient kills himself, his “loved ones” and the lawyers they hire are likely to interpret the act as *prima facie* evidence of the psychiatrist’s having committed medical malpractice (Szasz 1999).

Health Über Alles

Clearly, many Americans believe that the coercive medical control of most (bad) behaviors is justified and proper because those behaviors are diseases or are caused by diseases or are the causes of diseases. Barry R. Bloom, dean of the Harvard School of Public Health, states: “The real culprits behind heart disease, cancer, stroke, and injuries are *the underlying causes* of these conditions—tobacco use (leading to 19 percent of all deaths), unhealthy diet and inactivity (14 percent), alcohol (5 percent), infectious disease (5 percent), firearms (about 2 percent), and accidents (1 percent)” (1999, 92, emphasis added). What, one wonders, will people die of after all the preventable causes of diseases have been prevented?

When Health Trumps Liberty

When health is equated with freedom, liberty as a political concept vanishes. We understand and accept the person who prefers security over liberty, but we do not understand or accept the person who prefers disease over health, death over life.

In 1999, at the Eleventh World Congress of the World Psychiatric Association, Benedetto Saraceno, M.D., director of the World Health Organization’s Department

of Mental Health, urged psychiatrists “to embrace a conceptual shift that expands on the traditional boundaries of psychiatry . . . [and] serve people affected by violent conflicts, civil wars, and disasters . . . and displaced people, many of whom will suffer from anxiety disorders, depression, and substance abuse” (“Psychiatry in 21st Century” 1999, 25). (I am not aware of a psychiatric leader ever urging his colleagues to narrow the scope of psychiatry.) The pharmacrats’ agenda, based on the new *coercive-therapeutic concept of disease*, differs radically from the medical scientist’s agenda, based on the old *noncoercive-pathological concept of disease*. To advance their agenda, the pharmacrats shift the focus—their own and the public’s—from phenomenon to tactic, from objectively demonstrable *disease* to dramatically advertised *prevention and treatment*.

The medical doctor treats cancer of the lung. The political doctor treats smoking, preventable by legislation, litigation, and taxation, and curable with nicotine administered by any route other than inhalation. Sanctimony and hypocrisy replace honesty and self-discipline. The Renaissance popes preached celibacy and fornicated. Political doctors preach zero tolerance for tobacco and smoke. At the Fifty-second World Health Assembly, Surgeon General David Satcher publicly whined: “I was personally concerned to see delegates from many countries smoking . . . allowing harmful exposure of UN employees, visitors, and delegates to environmental tobacco smoke, a known carcinogen” (Satcher 1999, 424). Satcher did not engage in a more meaningful protest at the convention, such as walking out of smoke-filled rooms, nor did he propose a more meaningful protest in the pages of the *JAMA*.

Suicide prevention is another, perhaps the most dramatic, example of coercion masquerading as care. In September 1999, Surgeon General Satcher declared “suicide a serious public health threat” and proposed “educating the public to recognize when someone seems ‘at risk’ for suicide and how to better help that person get help. That includes doctors and nurses, but also the clergy and others who interact with people and hear about their problems. *We want coaches, we want schoolteachers, we want hairdressers* [to be informants]” (“Surgeon General Seeks” 1999, emphasis added). Satcher’s spokesman explained, “It’s simple, it’s understandable, and there’s *near universal agreement* that these 15 steps can prevent suicide” (*ibid.*, emphasis added). Recognizing that the term *suicide prevention* is a euphemism for psychiatric coercion is taboo; rejecting the premise that all suicide ought to be prevented is unthinkable. Satcher’s antisuicide proposals, like the wars on drugs and smoking, reek of hypocrisy. He must know that the suicide rate among physicians is two to three times that among the general public.

The Statist-Socialist Bias in Health-Care Thinking

The way we think about medical care and the language we use to talk about it are themselves problematic and deserving of attention. Health-care planners think in

terms of *other people's needs*, as determined by physicians or politicians. Patients think in term of their *own wants*, which they themselves determine. People buy health care *not because they want health care, but because they do not want to be sick*. This negative motivation creates a more intense consumer dependence on authority for health care than for other goods and services. On whose authority can or should the consumer depend? The physician's? The medical profession's? The government's? For the greater part of the twentieth century, it was not enough that the practicing physician be well trained. He also had to be *licensed by the state*. Medical licensure *by the states* was supposed to guarantee the public a high level of physician competence and therefore of medical care. By the end of the twentieth century, most Americans concluded, probably without giving the matter much thought, that this assurance was not enough, that the time had come to place their trust for the provision of reliable medical care in the *federal government*.

We have come to take our dependence on the federal government for *health protection* so much for granted that we no longer notice how it has infected the way we speak and think about *prohibitions* imposed on us by the state. On December 28, 1999, President Clinton proposed "a new initiative to *protect consumers from the illegal sale* of pharmaceuticals over the Internet." The proposed regulation, designed to protect "unsuspecting consumers [who] may fall prey to fly-by-night Internet pharmacies . . . , [will] identify, investigate, and *prosecute websites selling such items as: prescription drugs without a valid prescription*" (Office of the Press Secretary 1999, emphasis added). This is typical pharmacratic newspeak. The consumers Clinton offered to "protect" cannot be *unsuspecting* if they know how to use a computer and the Internet, nor can they be *prey* to unscrupulous vendors if their aim is to free themselves of the constraints of our prescription-drug laws. Depriving people of the opportunity to evade our draconian drug laws is here portrayed as an act of liberation-protection from health fraud. Pharmacratic controls may yet prove to be the Achilles heel of the unregulated Internet.

Loving Leviathan: Deifying and Medicalizing the State

The belief that providing health care to people is a function of the state is a part of the view of the state as a secular God. A few examples of the deification of the state, foreign and American, should suffice here (more generally, see Bovard 1999).

In 1928, Grigori Pyatakov, a Soviet leader, declared: "According to Lenin, the Communist Party is based on the principle of coercion which doesn't recognize any limitations or inhibitions. . . . moral, political, or even physical. Such a Party is capable of achieving miracles" (qtd. in Bovard 1999, 15). In 1997, a French communist official justified the Soviet Union's murder of millions of its own citizens as follows: "Agreed, both Nazis and communists killed. But while Nazis killed from hatred of humanity, the communists killed from love" (qtd. in Bovard 1999, 15).

The deification of the state was and is as popular in the United States as it was and is in Europe. In 1916, John Dewey declared, “The question of the limits of individual powers, or liberties, or rights, is finally a question of the most efficient use of means for ends. . . . [some] forms of *liberty may be obstructive*” (qtd. in Bovard 1999, 55, emphasis added). Alexander Meiklejohn—a less well-known but perhaps more influential political philosopher—abjured personal liberty more subtly but perhaps even more deeply. In 1935, he wrote that “Life, Liberty, and Property . . . may even be taken away [by the government] provided that the action by which this is done is justly and properly performed” (qtd. in Bovard 1999, 55). And in 1960, he declared, “Political freedom does not mean freedom from control. It means self-control” (Meiklejohn 1960, 13). Tito put it more simply: “The more powerful the State, the more freedom” (qtd. in Bovard 1999, 51). The pharmacratic version of this maxim becomes “The more powerful Medicine, the more health, and the more health, the more freedom.”

The socialization of health care in the United States is, for all practical purposes, a *fait accompli*. However, that reality has been obscured by the absence of a directly nationalized (“socialized”) system of health care, as well as by the American system being decked out with the vocabulary of choice, market competition, and patient autonomy. The result is deeply ironic: the more thoroughly socialized our health-care system becomes, the more physicians and patients alike complain that its shortcomings lie in its capitalistic excesses.

Health-policy expert Dan E. Beauchamp writes: “When I came to New York in 1988, my view of health care reform was captured in the image of the ‘big wave’ that would *transform everything, not only altering health care from a private to a social good but permanently reshaping the body politic, enlarging the communal sphere*” (1996, 113, emphasis added). Like a good Jacobin, Beauchamp dreamed of “universal health care . . . to change people and politics” (38). He acknowledges that he is not interested in improving anyone’s *private health*. “I began this task [formulating health-care policy],” he writes, “seeking to translate the public health viewpoint into the language of social justice and equality, suggesting that ‘public health,’ not ‘health care’ should be the primary or basic good” (1988, ix). Beauchamp is not interested in improving the health of any particular person as that person might want to improve it. To the contrary, he is interested in depriving individuals of their freedom to use their own funds to purchase medical care. “Republican equality would limit the power of money . . . over health policy . . . [and would limit] liberty to protect the health and safety of citizens as a body, the *public health—a central goal of all republican schemes of government*” (1988, 3 and 8, emphasis added).

By redefining freedom as the protection of the collective from disease, Beauchamp denies that he wants to abridge liberty: “The idea of liberty should mean, above all else, the liberation of society from the injustices of preventable disability and early death. . . . extending life and health to all persons will require some diminution

of personal choices. . . . [S]uch restrictions are not only fair and do not constitute abridgment of fundamental liberties, they are a basic sign and imprint of a just society and a guarantee of the most basic of all freedom—protection against man’s most ancient foe” (1999b, 109). According to Beauchamp, the market is a “prison [that] diminishes justice. . . . The truth of the market rests on a private and *interested* view. The truth of the political sphere rests on a more general and *disinterested* view” (1988, 51, 150). He concludes: “Giving everyone roughly the same level of care based on their need makes everyone aware that they are equals” (1988, 40). This statement is a proposal to use health-care policy to justify political coercion in the service of a dystopian goal that has no relation whatever to health as a medical concept. Finally, taking the New Deal as his model for social engineering, Beauchamp prescribes for us our state religion: “Our myth for the next American republic should be that *we do things together in order to live together*. This new myth would build on the New Deal and its ideal of national community” (1988, 155, emphasis in original). What we need, in short, is a New Leviathan led by a medical führer—“a new leader who battles on behalf of the people and launches the last big wave of reform, putting in place a powerful new institution that secures our health-care future and much else besides” (1988, 156).

In a similar vein, Howard Waitzkin, professor of medicine at the University of New Mexico, advocates reforming America’s medical services along explicitly socialist lines. In his book *The Second Sickness* (2000), he explains: “Under capitalism, illness is exploited for a variety of purposes by a number of groups, including profit-making corporations, health care professionals, and medical centers” (7). Waitzkin’s excuse for alcoholism illustrates the meshing of the psychiatric and socialist perspectives on drug abuse. “Alcoholism [according to Engels] was rooted finally in social structure; the attribution of responsibility to the individual worker was misguided” (67–68). Americans have accepted this viewpoint without any recognition of its Marxist, pseudoscientific roots.

Like Beauchamp, Waitzkin is more interested in creating “state power” and eliminating private medicine than in letting individuals choose the kind of health care they prefer. Physicians, Waitzkin declares, “hold class interests that often impede progress toward a more egalitarian distribution of goods and services. Doctors, like bankers and corporate managers, possess economic advantages and customary life styles that they do not willingly sacrifice on behalf of the poor” (2000, 211). Waitzkin evidently believes that degrading the rich would elevate the poor. The Soviet experience, one would have thought, has decisively disproved this fantasy, but not in Waitzkin’s socialist construction of reality: “The Soviet Union eliminated its chronic problems of epidemics and cut its infant mortality rate by more than half in one generation” (224). The Soviet Union also succeeded in increasing its adult mortality rate, reducing the life expectancy of its citizens by some two decades below that of people in the West or in Japan.

Most academic physicians now champion statist medicine as the embodiment of a higher, altruistic morality. Leon Eisenberg, a professor of psychiatry at Harvard, calls Milton Friedman “the high priest of laissez-faire capitalism,” as if capitalism were self-evidently sinful, and concludes his plea for socialist medicine with this self-flattering outcry: “Will we try to save our skins by delivering minimally adequate care on the cheap or will we stand up and be counted in the fight for universal health insurance?” (1999, 2256).

The right-thinking physician is now an advocate of merging medicine and the state. He does not call this merger “socialized medicine,” a taboo phrase. He calls it the “single-payer” system or “universal health-care coverage.” Speaking at a meeting in January 2000, Arnold Relman, the former editor-in-chief of the *New England Journal of Medicine*, endorsed “three examples of single payers: Britain, Canada, and U.S. Medicare. One advantage, he stated, was physician autonomy: British and Canadian doctors are ‘free to do what they want with the resources provided.’ U.S. Medicare, which [according to Relman] ‘is not socialized at all, exerts virtually no control over the practice of medicine’” (“Payer Failure” 2000, 1). Marcia Angell, editor-in-chief of the *New England Journal of Medicine*, declares: “In a 1993 editorial . . . I called for a universal, single-payer system and suggested that we could attain that goal by extending Medicare to all Americans. . . . Medicare is far more efficient than the market-based part of our health care system” (2000, 1664). Herbert Pardes, president of New York–Presbyterian Healthcare System, complains: “Academic medicine has been turned over to the marketplace and treated like a product. We need universal health care coverage to help both *indigent people and the institutions that serve them*” (2000, emphasis added). Relman’s views sound like nothing so much as the enthusiastic reports of liberals returning from their visits to the Soviet Union in the 1930s. The “single-payer” system, which Angell calls “market based,” has, of course, not the remotest similarity to what classical liberals call a “free market.” Finally, Pardes recommends that we return to the health-care system of the 1940s, with this difference: *every patient* should be in the same position of economic-existential dependence on the system in which the charity patient used to be.

Conclusions

The collectivization of American medicine, like the collectivization of much else in America, began during the presidency of Franklin D. Roosevelt. In 1940, in a speech delivered at the dedication of the newly established National Institutes of Health, Roosevelt declared: “The defense this nation seeks involves a great deal more than building airplanes, ships, guns, and bombs. We cannot be a strong nation unless we are a healthy nation” (qtd. in Fallows 1999, 68). With equal justification, Roosevelt might have said: “We cannot be a strong nation unless we are a prosperous nation.”

We have become a prosperous nation by separating the economy and the state, not by making the state the source of employment, as have the communists, with the

disastrous results now known to all. We can become a healthy nation only by separating medicine and the state, not by making the state the source of health care, as have the communists, with similarly disastrous results.

Long before the reign of modern totalitarianisms, English economist and statesman Richard Cobden (1804–65) warned: “They who propose to influence by force the traffic of the world, forget that affairs of trade, like matters of conscience, change their very nature if touched by the hand of violence; for as faith, if forced, would no longer be religion, but hypocrisy, so commerce becomes robbery if coerced by war-like armaments” (qtd. in *Ideas on Liberty* [February 2000], back cover). The same principle applies to medicine. As “affairs of trade . . . change their very nature if touched by the hand of violence,” so affairs of medicine also change their very nature if touched by the hand of violence and, if forced, cease to be forms of treatment, instead becoming forms of tyranny.

Americans’ love affair with pharmacracy now transcends traditional distinctions between left and right, liberal and conservative, Democrat and Republican (Szasz [1976] 1985). Even libertarians are often indifferent to the dangers posed by Leviathan, provided it has an M.D. degree and prescribes drugs (see, for example, McCloskey 1999). Physicians, who ought to know better but for the most part don’t, are perhaps the most naive and at the same time the most zealous advocates of medical interventions for all manner of human problems. Writing in *JAMA*, two physicians plead for a “comprehensive public health surveillance of firearm injuries.” Why? Because “Firearm injuries are a leading cause of death and disability in the United States” (Hayes and LeBrun 1999, 429). We are building a society based on the false premise that if *x* is a “leading cause” of death, then *x* is a disease and a public-health problem whose prevention and treatment justify massive infringements on personal freedom.

Clearly, the leading cause of death is being alive. The therapeutic state thus swallows up everything human on the seemingly rational ground that nothing falls outside the province of health and medicine, just as the theological state had swallowed up everything human on the perfectly rational ground that nothing falls outside the province of God and religion. Lest it seem that I exaggerate the parallels between these two total states and the religious nature of the therapeutic state, consider Vice President Al Gore’s by no means atypical remarks, offered in an address at Emory University on June 1, 2000. Pledging to wage the war on cancer with renewed vigor, he declared: “Within ten years, no one in America should have to die from colon cancer, breast cancer, or prostate cancer. . . . The power to fight cancer comes from the heart and from the human spirit. But most of all, it comes from being able to imagine a day when you are cancer-free.” His Web site carried his message under the banner headline, “Gore Sets Goal for a Cancer Free-America” (Gore 2000; see also Dalrymple 2000). Thus do Christian Science and the wars on diseases blend into political vapidty and pharmacratic tyranny.

Because much of the work of the pharmacrats entails legislation, regulation, and coercion, the need for lawyers expands even more rapidly than does the need for doctors. The steady increase in the number of lawyers compared to the number of physicians is consistent both with the expansion of pharmacratic tyranny and with the underlying conflict between health and freedom that so many people sense. In 1956, approximately 7,500 law degrees and 6,000 medical degrees were awarded in the United States, for a ratio of 1.2 law degrees for every medical degree. In 1996, 40,000 law degrees and 15,000 medical degrees were awarded, for a ratio of 2.6 to 1 (Brimelow 1999, 150).

America's drift toward pharmacracy has not escaped the attention of perceptive social commentators. "Our politicians," observes Andrew Ferguson, "are transcending politics. . . . How is it . . . that politicians who for years promised to keep government out of our bedrooms now see fit to invite their way into our souls? They have cast themselves as empaths; soul-fixing is their job. . . . Their bet is that America today wants a Therapist in Chief" (1999, 52). Indeed, the medical metaphors regularly used by our leaders—and by their wives and cabinet members—have made them seem such.

Actually, I believe, Americans want a therapist-in-chief who is both physician and priest—an authority that will protect them from having to assume responsibility not only for their own health care but also for their behaviors that make them ill, literally or figuratively. Pandering to this passion, politicians assure them they have a "right to health" and that their maladies are "no-fault diseases"; promise them a "patient's bill of rights" and an America "free of cancer" and "free of drugs"; and stupefy them with an inexhaustible torrent of mind-altering prescription drugs and mind-numbing antidisease and antidrug propaganda—as if anyone could be *for* illness or drug abuse.

Formerly, people rushed to embrace totalitarian states. Now they rush to embrace the therapeutic state. By the time they discover that the therapeutic state is about tyranny, not therapy, it will be too late.

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