reviews

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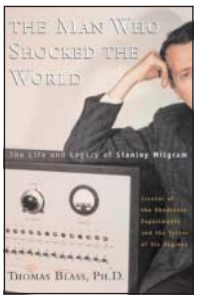
The Man Who Shocked the World: The Life and Legacy of Stanley Milgram

Thomas Blass



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Rating: ★★★★

The late Stanley Milgram fairly lays claim to be one of the greatest behavioural scientists of the 20th century. He derives his renown from of a series of experiments on obedience to authority, which he conducted at Yale University in 1961-2. Milgram found, surprisingly, that 65% of his subjects, ordinary residents of New Haven, were willing to give apparently harmful electric shocks—up to 450 volts—to a pitifully protesting victim, simply because a scientific, lab coated authority commanded them to, and despite the fact that the victim did nothing to deserve such punishment. The victim was, in reality, a good actor who did not actually receive shocks, a fact that was revealed to the subjects at the end of the experiment.

Milgram's interest in the study of obedience partly emerged out of a deep concern with the suffering of fellow Jews at the hands of the Nazis and an attempt to fathom how the Holocaust could have happened. His researches, like Freud's, led to profound revisions in some of the fundamental assumptions about human nature.

Milgram's experiments suggested that it was not necessary to invoke "evil" as a concept to explain why so many ordinary people do terrible things. Instead his work, and that of other social psychologists, suggested that much of what we do, we do automatically. Evil often occurs simply because we do not question our acts enough; instead our rationale arises from our trust in authority figures who are in "charge."

Items reviewed are rated on a 4 star scale (4=excellent)

The subjects in Milgram's original series of tests believed that they were part of an experiment dealing with the relation between punishment and learning. An experimenter—who used no coercive powers beyond a stern aura of mechanical and vacant eyed efficiency—instructed participants to shock a learner by pressing a lever on a machine each time the learner made a mistake on a word matching task. Each subsequent error led to an increase in the intensity of the shock in 15 volt increments, from 15 to 450 volts.

Actually the shock box was a well crafted prop and the learner an actor who did not receive shocks. Most of the subjects continued to obey to the end—believing that they were delivering life threatening 450 volt shocks—simply because the experimenter commanded them to. Although subjects were told about the deception afterward, the experience was a real and powerful one for them during the laboratory hour itself.

These groundbreaking and controversial experiments had—and continue to have—longlasting significance. The media have been obsessed with them since, repeatedly "re-discovering" them and re-reporting them as if they were amazing news.

Milgram's study demonstrated with brutal clarity that ordinary individuals could be induced to act destructively, even in the absence of physical coercion, and humans need not be innately evil or aberrant to act in ways that are reprehensible and inhumane. While we would like to believe that when confronted with a moral dilemma we will act as our conscience dictates, Milgram's obedience experiments teach us that, in a concrete situation with powerful social constraints, our moral sense can all too easily be overwhelmed.

The research was also conducted with amazing verve and subtlety—for example, Milgram ensured that the "experimenter" wear a grey lab coat rather than a white one, precisely because he did not want subjects to think that the "experimenter" was a medical doctor and thereby limit the implications of his findings to the power of physician authority.

The nuance of Milgram's conclusions has often been obscured by the superficial reporting of his work, which Blass, a US psychology professor, goes to some lengths in this important book to rectify. Milgram believed the true explanation of evil such as the Holocaust was linked to his experiments by their demonstration of "a propensity for people to accept definitions of action provided by legitimate authority. That is, although the subject performs the action, he allows authority to define its meaning."

Milgram: groundshaking experiments

We did not need Milgram to tell us that we have a tendency to obey orders. But what we did not know before Milgram's experiments was just how powerful this tendency is. And having been enlightened about our extreme readiness to obey authorities, we can try to take steps to guard against unwelcome or reprehensible commands.

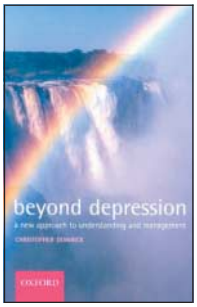
Many professions have taken heed of Milgram's work. The US army, for example, now incorporates his findings into its education of officers in order to illuminate the issue of following unethical orders. However, it is not clear that medicine has truly understood the implications of Milgram's work. How often are doctors or medical students in the position of having to obey "orders" or implicit expectations in hospitals or clinics, when they are uneasy about the ethics of doing so?

What is perhaps most intriguing about this book is not so much the dramatic implications of Milgram's work, but instead the insight that Blass gives us into the kind of unconventional mind required to devise groundshaking experiments that will continue to echo through the corridors of history long after much more mundane work currently dominating learned journals is forgotten.

Raj Persaud *Gresham professor for public understanding of psychiatry and consultant psychiatrist, Maudsley Hospital, London*

Beyond Depression: A New Approach to Understanding and Management

Christopher Dowrick



Oxford University Press, £19.95, pp 238
ISBN 0 19 852632 6

Rating: ★★★★

Opening my review copy of this book I was amazed to find my name in the acknowledgments and myself immediately encumbered with an obvious conflict of interest. It is a generous acknowledgment as my only contribution was a peripatetic meeting with the author that combined a conversation about life, the universe, and everything with demonstrating against the presence of President Bush in London in November 2003.

At a time when many well meaning, but surely misguided, people are pushing for financial incentives to be offered for the medical management of depression within the UK general practitioner contract, this is a book that is both brave and timely.

The World Health Organization describes depression as a common mental disorder characterised by sadness, loss of interest in activities and decreased energy, and rather vaguely differentiated from normal mood changes by the duration and severity of symptoms. WHO reports that worldwide 121 million people currently have depression and that an estimated 5.8% of men and 9.5% of women experience a depressive episode in any given year. These prevalences are rising every year and depression is predicted to be the world's second commonest cause of disabling disease by 2020. Christopher Dowrick asks whether there is an unprecedented epidemic of sadness and misery sweeping the world or whether, alternatively, we are in the process of altering our interpretation of our physical and emotional experiences and our understanding of the human condition.

Dowrick explores the many and diverse ways in which human culture and language have responded to the experience of suffering and distress and, in this context, finds the modern concept of depression to be stultifying in the narrowness of its vision and disabling in its allocation of a passive sick role to the sufferer. Set alongside this persuasive analysis is the knowledge that depression operates to the advantage of many powerful interests: pharmaceutical companies have made huge profits from the manufacture and promotion of antidepressant medication with an ever wider range of indications; mental health professionals and academics have built careers on creating and analysing an evermore complex classification of depression; general practitioners have sought refuge in the label as a means of controlling uncertainty in the consulting room and diverting attention from the causes, nature, and extent of human suffering; and politicians have found that depression is a convenient packaging of society's ills, which might otherwise require more fundamental solutions and a more equal allocation of hope and opportunity. I suspect that there are few general practitioners who have not prescribed antidepressant medication when what is needed is a home that is not overcrowded, damp, and squalid.

In an increasingly medicalised world obsessed with disease taxonomies, depression has become a procrustean label that fails to acknowledge the diversity of individual experience and further disables the labelled. In *A Fortunate Man,* John Berger asked, "What can the word 'depressed' mean to the depressed? It is no more than an echo of the patient's own voice."

Dowrick proposes systematic avoidance of the label and argues that this opens up many more opportunities for restitution. He prefers to agree with his patient that "something bad has happened" and, in so doing, to normalise distressing experience and oppose the increasingly pervasive expectation of a continuous state of happiness and contentment. With less diagnosis and more understanding, fewer prescriptions and more listening, it may be possible to locate renewed meaning within the patient's life story and so find a way forward.

How I wish that Dowrick's understanding was shared by more mental heath professionals, policy makers, and politicians, and that a copy of this challenging book was open on health secretary Patricia Hewitt's desk.

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ART

Touch Me

An exhibition at the Victoria and Albert Museum, London SW7, until 29 August
www.vam.ac.uk/vastatic/microsites/1376_touch_me/

Rating: ★★☆☆

Museums usually instruct us not to touch their displays; however, the opposite is the case at this exhibition, developed in collaboration with the Wellcome Trust, where visitors are encouraged to handle many of the objects.

Touch Me explores aspects of how we relate to each other, and to the objects we use every day, through touch, which the curators argue is a neglected sense. Partly resembling a degree show for a design course with an emphasis on improving the tactile quality of products and partly like an amusement arcade featuring quasi-scientific experiments, the exhibition aims to stimulate our thinking about our sense of touch and how we use it.

Several of the innovative products are witty. Rather than flicking a switch, visitors can activate an electric lamp called the *Watt? Light* by drawing a line with a lead pencil, to complete a circuit printed on a sheet of paper. The light is extinguished by rubbing out the line with an eraser. Whether the additional tactile experience provided would be worth the hassle on a daily basis is debatable; however, Paul Cocksedge's design is certainly thought provoking.

Although using our thumbs in place of fingers looks awkward, we use them increasingly, to text messages on mobile phones and to manipulate other electronic gadgets. Julia Leihener's *Thups,* glass or plastic cups hooked over drinkers' thumbs rather than held, provide a further, light hearted use for these previously neglected digits.

Getting the thumbs up: *Thups*

A new area of research highlighted in the exhibition is the development of tactons or "tactile icons," like the vibrations already used to alert mobile phone users to incoming calls. In the future, vibrations of differing duration, frequency, or strength could be used to provide more information about the caller or type of call, providing that we can learn to differentiate new tactile stimuli.

Although Touch Me provides many opportunities for interaction, which engage adults and children alike, the curators acknowledge that the exhibition raises more questions than it answers. Even its central hypothesis, that we are becoming dissociated from our sense of touch in the modern world, is not proven. Ultimately, the exhibition's open ended conjectures appear as muddled thinking, from which it is difficult to draw meaningful conclusions.

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PERSONAL VIEWS

Let the buyer beware

The Roxy market in the Adjamé district of Abidjan in Côte d'Ivoire is well known among the city's poor people. With hundreds of vendors, it is a vast expanse of shelters and parasols under which all kinds of drugs in all sorts of forms—pills, syrups, powder, suppositories, injectables, ointments—are displayed in a jumble on tables or in baskets. The drugs are constantly exposed to dust, sun, and changes in weather that can affect their quality. It is common to find drugs sold without their original packaging and repackaged in plastic bags with no mention of the drug's name, active ingredients, or expiry date. Nearly all the vendors are women, and more than a third are illiterate. None has knowledge of drugs or any medical training—but this does not mean they aren't ready to quickly diagnose an illness or try to decipher a prescription so they can provide a drug, though their choice is more likely to be determined by what they have in stock than the actual cause of the illness.

The drugs in the market can be divided into two broad categories. The first is drugs that can also be found in legal pharmacies and street markets. They find their way to Roxy from legal wholesalers and pharmacists. Indeed, the legal pharmaceutical sector supplies about 48% of the stocks of drugs in the country's illegal street markets (www.remed.org/fichiers/ReMeD22.pdf). Some wholesalers have set up a supply system to the illegal outlets so that all the groups of drugs present in the legal pharmacies can also be found at cheaper prices in the illegal market. This new business line is helped by the fact that the street sellers buy on a cash on delivery basis, while the legal pharmacists negotiate payments by credit. The delivery cars operate at night or early in the morning. Some drugs are stolen from pharmacies by employees and sold in the street market at a cheaper price. It is often possible to see drugs labelled "free sample, not for sale," provided by medical representatives who sell the samples intended for doctors.

Drugs donated to charities are also often found in the street market. These drugs are often not suited to the needs of the receiving population and so will be sold by the organisations. In addition, some drugs made in Europe are in the street market—probably sold on by unscrupulous Europeans—even though domestic manufacturers are licensed to make the same drugs.

> The substandard drugs are often those in high demand for AIDS and malaria

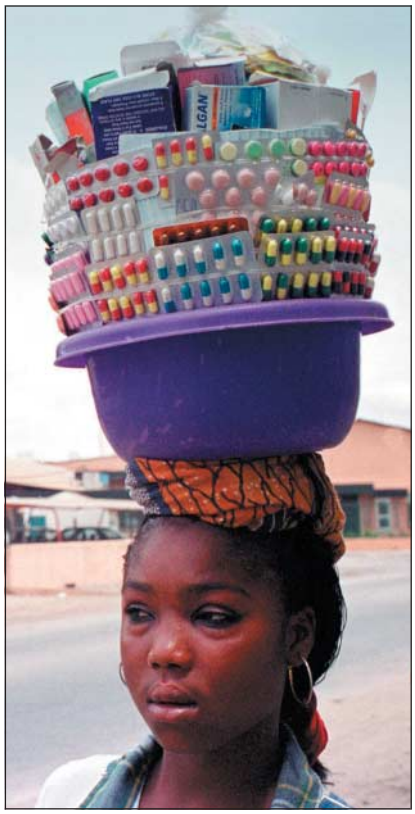
The second category is the drugs found only in the illegal street markets. These are drugs that have escaped government regulation and are essentially those smuggled into the country past customs agents (or with their connivance). They are usually not registered in Côte d'Ivoire and mostly come from Ghana, Nigeria, and India. Also in this category are the illicit Chinese traditional medicines, a burgeoning market throughout the country. They are distributed by young jobless Ivorians, under the guidance of a Chinese boss. The vendors, unable to read the Chinese characters, give the medicines their own designations to identify the product. Of course the accompanying leaflets, if any, are likewise illegible to the consumers.

The few studies that have looked into the problems caused by the spread of illegitimate channels of drug distribution in less developed countries have all found that a large proportion of the drugs are of low quality. This is partly because the drugs are sold after the expiry date or stored in bad conditions but mostly because the active ingredients are lacking or even wrong, owing to irregularities in the manufacturing process, whether intentional (in the case of counterfeit drugs) or not (substandard drugs). Up to 25% of the drugs consumed in poor countries are counterfeit or substandard (*Journal of Advanced Nursing* 2004;46:338-9).

Because of the absence of controls in markets like Roxy, the proportion of poor products sold there must surely be higher, but we do not have any reliable data. The substandard drugs are often those in high demand for life threatening conditions such as AIDS and malaria. Inevitability, their ineffectiveness leads to clinical aggravations and even death. The situation is made worse by the encouragement of prompt self treatment for diseases such as malaria.

> Many visit the street vendors to avoid doctors' consultation fees

Although the market's customers may sometimes need a prescription, many visit the street vendors to avoid doctors' consultation fees. Less than 10% of Côte d'Ivoire's population has health insurance. The exact proportion of people buying medicines from the illicit outlets is unknown, but estimates are that in some African countries as many as 85% of patients may visit these ignorant and dangerous bogus "doctor-pharmacists." Occasionally the authorities publicise the dangers, but nothing concrete is being done to eradicate the problem, by either the authorities or the pharmaceutical sector.



ISSOUF SANOGO/AFP/GETTY

Pile them high, sell them cheap

The paradox is that these illegal vendors pay daily fees to the city council to occupy space on the pavement or the street. Sporadically the police mount raids and arrest the vendors and confiscate their merchandise, but usually the owners can get their goods back by paying the police.

The country needs a much stronger political will and enforcement of drug regulation to beat this rapidly expanding problem. However, the country's current political and economic crisis makes this unlikely. Instead it is up to those in Côte d'Ivoire's pharmaceutical sector to face up to their responsibilities and fight this dishonouring of their profession.

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Can Labour take the NHS to market?

Now that the Blair government's third term has started, its health policies are becoming clearer; ironically for a Labour government, at their heart is a market.

The Conservative government of the 1990s tried to introduce an "internal market" in health care in which hospital services were intended to be market tested to make them more efficient and to offer patients more choice. It could never really have succeeded at that time; a right wing government, while being able to take for granted support from its own followers, would never have been able to convince more left wing voters to trust in a market philosophy.

Only a government able to gain the confidence of more egalitarian minded voters would stand a chance of implementing a market policy. That is what has happened: the New Labour government seems to have made the notion of a healthcare market its own, only this time it's real, not "internal."

Markets work most effectively when supply exceeds demand, so the government's first task was to loosen the constraints of the "old" NHS and begin to increase the number of potential service providers. This has been done in several ways: firstly, contracts between the service commissioners (currently the primary care trusts) and their providers have been made less structural and more functional, so that outputs (for example, numbers of operations) have become more important than inputs (such as numbers of hospital beds or consultants).

Secondly, the number of providers is being increased, ostensibly to overcome long waiting times, but actually to produce some open competition to create choice and, in the longer term, to drive down the cost of care. The independent sector has been persuaded to enter the fray, with explicit inducements available for the first few years at least. The current independent range of models (mainly companies offering specific surgical procedures) should be expected to expand, and other patterns may emerge: accredited general practices offering surgical procedures, pharmacy companies (or even hospitals) competing for primary care, overseas companies bidding for business, and so on.

The creation of foundation trusts is also intended to harness the innovation that has not traditionally been encouraged in the NHS, so that such organisations may diversify and develop to meet the demands of the growing healthcare market. The distinction between public and private supply is likely to become irrelevant; the public aspect of the NHS will be defined only by its funding and control.

Underpinning these developments is the rhetoric of fixed tariffs, supposed to allow variations based on quality and convenience, rather than price. The premise that variations in activity should not affect price may sound reasonable, but it is unsustainable in the longer term, since costs vary even if prices do not. Every business has fixed costs, but once these are covered, doing more of the same becomes relatively cheaper; offering suppliers the full price is unnecessary, and distorts their profit.

Conversely, removing marginal activity at full price amplifies suppliers' losses in a way that will eventually bankrupt them. In an open market, the three variables are quality, quantity, and price; if a healthcare market is to succeed, it will need to be no different.

So much for technicality; what about culture and values? Can a health market succeed in a society that still holds egalitarianism and equity so dear? It depends on the power of commissioning. In theory the primary care trusts, probably working in ways that give them greater economy of scale, could regulate the market by marrying the healthcare needs of their populations, the resources available, and the range of services required.

> Can a health market succeed in a society that holds egalitarianism and equity so dear?

This strategic role would inform the decision making of local purchasers, thus ensuring that the market retained a degree of efficiency, and did not result in fragmented, inappropriate services. If that could be made to work, something unique will have been created, a pluralistic system of provision offering equitable services under the control of the public sector. However, this can work only if the strategic commissioners learn to use powerful, mature contracts based on partnership and interdependency rather than the simplistic "win/lose" contracts we generally have now.

Finally, there are the politics; a secretary of state coming from the Department of Trade and Industry may be assumed to favour trading models of health care, particularly when backed by a prime minister so closely associated with market mechanisms. But with a smallish majority of MPs, prepared to show their disapproval of non-traditional Labour policies, how would a different premier react, one whose faith in the market was not so well established?

The reality is probably pragmatic; the market will survive and thrive only if it begins to produce results, and soon.

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SOUNDINGS

Be alert

The more things change, the more they stay the same—cynical old men suckering gullible and vulnerable young men into doing their dirty work for them. You've just experienced it in London, I saw it for years in Northern Ireland, and Siegfried Sassoon wrote about it in 1918: "If I were fierce and bald and short of breath, I'd sit with scarlet Majors at the Base, And speed glum heroes up the line to death."

You'll get used to it. More visible security, regular searches, frequent false alarms, delays on trains and buses—all these things will gradually soften like music into the background. Life has to go on, the anxiety will fade as you adjust to a different dynamic, you'll go back to talking about football and the weather, and patients will still want antibiotics for colds and sore throats even as the sirens wail. Humans aren't genetically designed for absolute tranquillity, and a bit of uncertainty is probably good for us.

> Humans aren't designed for absolute tranquillity

Statistically the chances of being involved are slight. During the Troubles about 3000 people were killed, and in that same period the death toll on the roads was over 6000. But the increased threat does make you more alert to small things, a little bit more cautious and thoughtful.

I remember once driving to a house call when I noticed a cardboard box at the side of the road. I stopped the car and sat for a while, pondering. It was just a cardboard box on a small country road, almost certainly just a piece of stray litter; no wires, no traditional whiff of cordite, no sound of merry gunfire in the distance, no sign of any "insurgents," nothing at all suspicious.

I got out of the car at a prudent distance, and looked sternly at the box; I consider myself an alpha male. It looked back at me, unblinking. Observing the conventions, it exuded a faint air of menace: "You're alive, you're dead," it seemed to be saying, "it really doesn't matter to me." For a long moment neither of us moved.

Then I turned around and made a detour which cost me 10 miles; fortune may favour the brave, but the devil hates a coward.

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