Sickness unto Death: Medicine as Mythic, Necrophilic and Iatrogenic

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The sick in the grip of contemporary medicine is but a symbol of humanity in the grip of its technique.—Wolfgang Jacob

A CRITIQUE of medicine is imperative in order to address the problems of the medicalization of society and the increasing evidence of physician-induced death and disease (iatrogenesis), and more importantly to make possible a pushing beyond institutionalized views of health and illness. By using an inductive cross-disciplinary analysis, the author's 13 years of experience in the hospital system will be integrated with the perspectives of sociology, philosophy, psychiatry and political science.

Medicine thrives on the maintenance of polarization—expert versus laity, superior versus subordinate, healthy versus sick, infallible versus fallible, physician versus patient. In effect, medicine today legitimizes and lives out an ethic of domination that is profoundly destructive.

Dubos has stated that "complete and

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lasting freedom from disease is but a dream." The medical profession seems to have turned this dream into a nightmare. Instead of offering health, physicians offer medically induced paralysis, dependence on machinery, invasive diagnostic procedures ("invasive" procedures are distinguished from "noninvasive" procedures when in reality the distinction is between visible and invisible invasion), unnecessary surgery and medication—until the patient's torment eventually lies in not being able to die. As Illich states:

> The new experience that has replaced dignified suffering is artificially prolonged, opaque, depersonalized maintenance. Increasingly pain killing turns people into unfeeling spectators of their own decaying selves.[1(p154)]

Once the medical and legal professions have defined life as a beating heart or a brain wave, technology becomes primary and living, only not dying. The present health care system fosters fragmentation; processing sickness into raw material for institutional enterprise[1(p170)]; and promotes the interests of science over the needs of society.[1(p254)]

MEDICINE AS MYTHIC

Whenever man has thought it necessary to create a memory for himself his effort has been attended with torture, blood, sacrifice.—Nietzsche

The medical profession perpetuates and lives out myths in order to ensure its continual existence. It receives legitimation for what it claims to do rather than for what it does and hence gains access to a brand of infallibility. See "The Politics of Medical Deception: Challenging the Trajectory of History," in this issue. The element of mystery is enhanced by the wearing of white, the masks and sterility of the operating room, the use of certain language and use of awe-inspiring symbols of "phallotechnic"[2] power from the scalpel to the intraaortic balloon pump.

On some level the patient is convinced that physicians and their technological devices are in and of themselves good. Questioning by the patient is viewed by the physician as suspect, for it suggests a lack of faith in those who define what is good and bad, healthy and sick. The client gives up the role of an independent adult, thereby protecting the esoteric foundation of the profession's institutional authority.[3(p143)]

The client ultimately becomes a captive in the closed universe of practitioners established in an official position in society.[3(p116)] These "expert" practitioners have come to play a role previously reserved for ministers of religion, using scientific principles as their theology, technologists as acolytes and the hospital as church.[1(p253)] As illustrated by Parsons, in the Judeo-Christian world the clergy is clearly the primary historical matrix from which the modern professions have differentiated.[4(p537)]

The most all-pervasive medical myth is that the physician has control over life and death. The medical profession reinforces this myth by defining death broadly in order to make feasible "bringing *back* to life." In the hospital this myth is reenacted in the form of cardiac arrest. Cardiac arrest is generally defined as a sudden, unexpected death. What it often means in the hospital setting is an irregularity of the heart rhythm (ventricular fibrillation)

which if left untreated eventually leads to death. Often a cardiac arrest is precipitated by the physician performing a procedure such as cardiac catheterization, pericardial tap, surgery or the administration of medication. In these instances the patient is "brought back to life" by terminating the procedure or by giving an antidote for the medication.

After witnessing countless so-called cardiac arrests, it became clear to me that once someone has died, that person cannot be brought *back* to life. Death is an irreversible process. When patients do in fact respond to treatment they have not yet died. The person whose heart has been shocked and drugged back into beating again often "survives" with extensive brain damage. Those who have lost the ability to breathe on their own are "maintained" on a respirator. Often this results in merely prolonging the lives of those who will later die a mechanized, sterile, prepackaged death. In fact, in the hospital no one "dies." Patients "expire," "cease to breathe" or are "lost." This win/lose terminology permeates medical language and alludes to the fact that physicians are playing a game.

Cardiac Drama

Cardiac arrest offers high drama. Its occurrence is announced over the hospital loud speaker as a "CA," "Mayday," or "Code Blue." The cardiac arrest team responds by rushing to the location announced. The patient often suffers several crushed ribs in the initial effort to resuscitate the heart effectively. Treatment of the patient is rarely synchronized, with each team member arriving and doing what he or she knows best. Tubes are introduced, drugs are administered via every possible route (intravenous, intracardiac, etc.). Blood is transfused and shed (for analysis) simultaneously; however, although physicians can pump blood into the body, they cannot make it flow. Their attempt to instill the "life force" often fails and death becomes the ultimate form of consumer resistance to medicalization.[1(207)]

For more than a century researchers have shown that the environment is the primary determinant of any population's state of general health.[1(p17)] The myth that the physician has control over life and death persists despite growing evidence to the contrary. Belief in this myth has resulted in widespread addiction to medical intervention. What is obscured by this is the fact that disease itself is largely self-limiting, and death, natural. Once the physician stepped between humanity and death, the latter lost the immediacy and intimacy gained years earlier.[1(p199)] "The good death has irrevocably become that of the standard consumer of medical care."[1(p198)]

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Manipulative Misuse of Language

DEFINITIONS

According to Arendt, "words can be relied on only if one is sure that their

function is to reveal and not to conceal."[5(p163)] The language of medicine is at times very revealing. In the *Oxford English Dictionary* (OED) the word "patient" is defined (the author's emphasis in italic) in part as (1) bearing or enduring (pain, affliction, trouble or evil of any kind) with composure, without discontent or *complaint;* (2) *under*going the action of another, passive; (3) a person *subjected* to the supervision, care, treatment, or correction of someone; and (4) a person or thing that *under*goes some action, or to whom or which something is done, that which receives impressions from external agents, a *recipient*.

The reader should also note that the OED definition of "woman" includes: with allusion to their position of inferiority or subjection (phr. to make a woman of, to bring into submission); and the definition of "object" includes (1) an object of pity or relief, an afflicted person or thing of pitiable or ridiculous aspect, a gazing stock ("Women are more glorious objects." Greene, *Perimedes* 1588); and (2) the thing (or person) to which something is done, or upon or about which something acts or operates.

An analysis of the medical profession makes it blatantly clear who the subject is, as well as the interchangeability of the words—*women, patient, object*. The role of patient is patterned after the role of woman—hence women patients are doubly cursed.

This definition implies a superior/subordinate relationship between health care provider and patient. This type of relationship cannot be a healing one. The fact that patients are often labeled, referred to and treated by medical personnel as "vegetables," "turkeys," "gorks," "crispy critters" (burned patients) and "scrunches" (accident victims) suggests instead an unhealthy, unhealing relationship in which the patient is dehumanized.

SYNTACTIC EXPLOITATION

Stanley exposes some of the ways in which language is used by speakers to convince other persons that the speaker is right.[6] Arendt describes one such process: "What first appears as a hypothesis . . . turns immediately . . . into a 'fact,' which then gives birth to a whole string of similar non-facts."[5(p109)] This leads listeners and readers to believe that they have a comprehensive understanding of events; they forget the purely speculative character of the entire process.

Overuse of such words as *never, always, fatal, inoperable, must;* and phrases such as "I'll *give* you six months to live," "These are doctor's *orders,*" and "Do as I say or find another doctor" serve to further intimidate or convince the "laity" that the physicians are not only right but infallible.

Stanley defines the use of syntax to deceive or mislead the unwary hearer as syntactic exploitation.[6] One instance of this is the use of deletion to suppress information required by the hearer for understanding of the message. As Marcuse illustrates, "What people mean . . . is related to what they don't say. Or, what they mean cannot be taken at face value—not because they lie, but because the universe of thought and practice in which they live is a universe of manipulated contradictions."[7(p194)]

The use of language to accomplish deletion of the truth is a common occurrence in the health care system. Following are examples of deletion that can be observed:

- "You hemorrhaged during surgery but we managed to get everything under control" deletes such explanations as "The hemorrhage was due to the surgeon's nicking an artery."
- "Your child is not responding to our treatment" deletes such explanations as "The treatment instituted was not indicated."
- "She became confused and combative so we had to restrain her" deletes such explanations as "Due to medication she was given."
- "She went into congestive heart failure" deletes such explanations as "She was given too much intravenous fluid too rapidly."
- "Everything possible is being done for her" deletes such explanations as "Even if it requires painful, dehumanizing, dangerously unnecessary procedures."
- "This medication will clear up your inflammatory process" deletes such explanations as "It may cause cataracts (requiring surgery), necrosis of the hip (requiring surgery), diabetes (requiring insulin), fluid retention (requiring salt restriction), psychosis, hirsutism, acne, peptic ulcer, insomnia, pancreatitis, etc."
- "She died suddenly" deletes such explanations as "Due to a punctured heart, which occurred during a diagnostic procedure."

Another instance of syntactic exploitation described by Stanley is the use of sentence structure to convince the hearer that there is a message available when in fact the utterance is meaningless. An example might be a physician "explaining" to a patient the reason for transfer to another unit of the hospital: "We are going to put you in intensive care because you are having multifocal PVCs and you need to be given some IV Xylocaine."

Other medical examples might include:

- Explaining a diagnosis: "You have thromboangiitis obliterans."
- Explaining the results of surgery: "The operation resulted in the expected outcome."
- Responding to an inquiry regarding a patient's condition: "She is being maintained on a respirator, her blood gases are off, but she's doing as well as can be expected."

The use of the passive voice is also a means of obscuring meaning by making the agent unclear and by appealing to some unspecified authority. The phrases *it is thought, it is understood* and *it is known* imply that underlying a particular statement is a great body of universal agreement.[8] In describing a disease as incurable, what is obscured is *who* is unable to cure it. When an operation is termed "mutilating surgery," who is doing the mutilating is unclear. When "The diagnostic test resulted in a stroke" or "Radiation has been improperly utilized" again the agent is unknown.

Awe, Ignorance and Fear

At most, the noncommunication taking place may convince the person that the

physician is intelligent. In other words, the physician attempts to convey a high level of intelligence corresponding to a high level of unintelligibility; that is, using highly technical language that laypersons cannot be expected to understand. It also serves to discourage any further questions or attempts to communicate. In effect, language is used to instill a sense of awe, ignorance and fear in the laity.

Labeling is a means of dehumanizing both the persons labeled and the person doing the labeling. It is a process that can creep into language and a way of viewing others without being fully aware of the objectification taking place. Evidence of this exists in casual conversations, nurses' notes, reports and written referrals to other agencies or other members of the health care team.

Persons who are labeled "unmotivated," "combative," "demanding" or "confused" are often treated in a way that serves to reinforce these very characteristics. By labeling a person "confused," one creates an excuse for not explaining treatments, tests, procedures, etc.; the medical professional "knows" in advance that the person would not understand. The patient becomes locked into a system where things are being done *to* her or him. All sense of autonomy or self is cancelled out. What is ignored is that "confusion," "combativeness," etc., are often not symptoms of a disease but a reaction to the sickness of the system.

MEDICINE AS NECROPHILIC

We shall have to learn to refrain from doing things merely because we know how to do them.—Sir Theodore Fox

One can say that all we know, that is, all we have the power to do, has finally turned against what we are.—Valéry

When technical knowledge is separated from ontological reason, the science which it dominates becomes dogmatic, manipulative and destructive.—Mary Daly

The sense of awe, fear and ignorance of the laity, combined with the established infallibility and omnipotence of the physician, results in what Illich describes as a "morbid society" demanding universal medicalization. This morbid society frequently finds its demands met by an equally "morbid medical profession."[1]

Fromm points out that the term *necrophilia* (generally defined, as "love of the dead") has not generally been viewed as a character trait, a trait that is rooted in passion, the soil from which its more overt and cruder behavioral manifestations grow. He describes necrophilia in the characterological sense: the passionate attraction to all that is dead, decayed, putrid, sickly.[9(p362)] The process or anti-process of developing this character trait in physicians begins in medical school. As one physician recalls:

> One of the first things we had to do was dissect a cadaver. I didn't think I could. But they started us on the back, so it was several weeks before we saw the face; by that time it didn't seem so bad .... You just see so much, something changes in you.[10]

The repetition of horror scenes eventually results in the inability to be horrified. This perspective leads to the ability to describe "a beautiful case of carcinoma," the excitement over "discovering some good pathology," the inappropriate laughter at the devastation and powerless-

ness of the "other." It is illustrated by a slide presentation for medical students in which "a dying woman's emaciated body and huge swollen belly were presented: 'Now this is Bubbles, and as you look into her lovely eyes. . . .' Students laughed."[11]

Fromm has stated that the "core of sadism is the passion to have absolute and unrestricted control over a living being. . . ; patients in hospitals offer the possibility for sadistic satisfaction."[9(p323)]

The Search for Sickness

Illich correlates the diagnostic bias in favor of sickness with the frequency of diagnostic error.[1(p93)] He points out that diagnosis intensifies stress, defines incapacity, imposes inactivity and focuses apprehension or nonrecovery, uncertainty and dependence on future medical findings, amounting to a loss of autonomy for self-definition.

The fixation on diagnosis is illustrated by the practice of putting elderly people through a series of tests that involve fasting, hours on an x-ray table and the introduction of needles, tubes and dyes into their systems. All this is done to determine, and document on the chart, the accurate diagnosis. Yet the elderly and debilitated are often not in condition to tolerate these tests. Naming the diagnosis seems to take precedence over healing.

Necrophilia is also characterized as the passion to transform that which is alive into something not alive. The fact that patients are reduced to objects being repaired rather than persons being helped to heal is symptomatic of this passion. The ability to feel, to respond, to channel anger into creativity is replaced by a balm of indifference, apathy and passivity administered in the form of daily doses (treatments) of narcotics, sedatives, tranquilizers, mood elevators, antidepressants, hormones, etc. The transformation of that which is alive into something not alive is accomplished by psychosurgery. Cosmetic surgery serves the purpose of transforming the natural (ugly) into the artificial (beautiful), a process of universal standardization nurtured by the mass media and all the allied professions. One of the most flagrant examples of the use of cosmetic surgery to transform something natural into something artificial is transsexualism, a process analyzed in depth by Raymond.[12]

Necrophilia is also characterized by an exclusive interest in all that is purely mechanical. Proust observed that great physicians often show themselves outside of their specialty to be lacking in sensitivity, intelligence and humanity; having abdicated their freedom, they have nothing else left but their techniques.[13(p51)] This attribute of necrophilia is implied in de Beauvoir's definition of the "serious man" as one "who wills himself to be a god, but he is not one and knows it."[13(p52)] He becomes obsessed with controlling at least some specialized aspect of his world and often expresses his obsession by technological intervention.

Professional Values

Once the destructive, one-dimensional orientation of the professions has been exposed, the values of professional life are open to question. Woolf has said of persons who are highly successful in their professions:

> They lose their senses. Sight goes.... Speech goes.... Sound goes.... They lose their sense of proportion—the relations between one thing and another.... Humanity goes.... What remains of a human being who has lost sight, sound and sense of proportion?[14(p72)]

These technological troglodytes approach the world as a conglomerate of things to be understood in order to be used effectively. They have sacrificed life in the worship of the idol of technology.

Parsons has written that the teaching hospital "has moved from purely clinical concerns for the immediate welfare of its patients to concomitant emphasis on *use* of the patients and facilities for the training of physicians."[4(p543)] The fact that a facility is a "teaching hospital" is used to justify a multitude of horrors. Just what is being "taught" is never questioned.

A lack of logic and insight leads many physicians to conclude that the medical, technological "we can" somehow implies "we ought." The realm of what medicine actually attempts to do has expanded almost beyond belief. In the face of this expansion, medicine has continuously failed to develop an ethic commensurate with the development of technology.[15] Medicine has also failed to project the long-range consequences of its aspirations and actions to the point that "aims no longer guide inventions; inventions reveal aims."[14(p210)]

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It becomes clear that the health-denying effect of the "health professionals" destroys the potential of people to deal with human weakness, vulnerability and uniqueness in a personal, autonomous way.[1(p33)]

> In order to become vehicles of freedom, science and technology would have to change their present directions and goals; they would have to be reconstructed in accordance with a new sensibility... the demands of the *life instincts*.[15(p19)]

MEDICINE AS IATROGENIC

The sick person is the garden of the physician.—Swahili proverb
Every profession is a conspiracy against the laity.—George Bernard Shaw
For the sick, the least is best.—Hippocrates

The word *iatrogenic* is defined in *Dorland's Medical Dictionary* as "resulting from the activity of physicians." Originally applied to disorders induced in the patient by autosuggestion based on the physician's examination, manner or discussion, the term is now applied to any adverse condition in a patient occurring as the result of treatment by a physician or surgeon. Illich points out that among murderous institutional torts, only modern malnutrition injures more people than iatrogenic disease in its various manifestations.[1(p26)]

Women the Targets

For as long as the present system of patriarchal medicine has existed, women have been the primary targets of iatrogenesis. The so-called first wave of feminism

crested in this country at the same time that the field of gynecology was receiving professional recognition. The "second wave of feminism" has coincided with an escalation of unnecessary and abusive gynecological intervention, including unnecessary surgery, prescription of controversial drugs (DES, Depo-Provera and birth control pills), sterilization abuse of black and third-world women, etc.[11,16-19]

A recent study reported in the *New England Journal of Medicine* states that: "The evidence for a connection between the use of conjugated estrogens and the development of endometrial cancer *seems rather persuasive.* Caution is urged . . . in view of the absence of data both from similar epidemiologic studies in other populations and from follow-up studies. Such information is necessary before policy conclusions can be drawn."[20]

This mentality was recently reflected in a statement made by an executive of a large food-processing corporation regarding the use of carcinogenic food additives: "Chemicals should have the same rights as individuals . . . innocent until proven guilty." The fact that the price paid for the proof is the lives of women is not considered.

As Daly clearly points out, "there is a refusal to acknowledge the evidence of medical morbidity, in this case, specifically, refusal to acknowledge the reality of estrogen-related deaths. As usual, we are told that there isn't enough evidence, that the link-up between drugs and death has not been 'proved.' Clearly, no matter how many women die, it still will not be proven to those who do not want to know."[21]

Joseph Chilton Pearce, in *The Crack in the Cosmic Egg,* relates the experience of his wife, Patricia Ann Pearce. Her grandmother died of cancer and all the females scrupulously avoided all the maneuvers rumored to have possibly caused the horror. Then in neat diabolical two-year intervals her favorite aunt died of cancer and her mother developed cancer but survived the radical-surgery mutilations. Her own debacle occurred in spite of constant submissions to the high priests for inspections and tests. The medical center that had attended her requested that her teenage daughter be given six-month checkups forever after, since they had found and thoroughly advertised that mammary malignancies in a mother tended to be duplicated in the daughter. Surely such duplications do occur, in a clear example of the circularity of expectancy verification, the mirroring by reality of a passionate or basic fear.[22(p8)] Added to the circularity of expectancy verification is other evidence of medical intervention as a cause of cancer in women: "routine exploratory examinations to detect the early phases of breast cancer may be causing extra cases of cancer through widespread use of X-ray radiation."[23] As Rennie warns: "the human organ most sensitive to radiation-induced cancer is the human breast—more sensitive even than bone marrow or thyroid tissue. . . . We should be wary of even the smallest radiation doses to that organ."[24]

Iatrogenic Despair

A physician's unawareness or misunderstanding of the role emotion plays in disease may not only prevent cure but may precipitate and perpetuate illness.—Peter Reich and Martin J. Kelly

An unawareness or misunderstanding by physicians of the role emotion plays in disease is reflected in a recent article entitled "Suicide Attempts by Hospitalized Medical and Surgical Patients," which was written by two physicians and appeared in the *New England Journal of Medicine*.[25]

The authors surveyed all suicide attempts in Boston's Peter Bent Brigham Hospital for a period of seven years. Women outnumbered men 13 to 4. Of the total of 17 patients surveyed, 5 had been hospitalized for the evaluation of "vague complaints" listed as headache, abdominal pain, seizures, gastrointestinal bleeding and addiction. These persons attempted suicide, the authors report, "when the *validity* of their medical symptoms was being *challenged*." Subsequently their "*demands* escalated," and the staff became increasingly "*rejecting*." (Italics are this author's emphasis.) From a physician's viewpoint these individuals were not willing to accept the fact that the physician could not find the etiology of their complaints; their societally induced expectations were seen as demands and the staff's rejection of them viewed as justifiable under the circumstances.

Two others had been admitted for the management of pain. Their medical problems were peptic ulcer and arteriosclerosis. "They both slashed their wrists when staff members *expressed disbelief* of the *reality* of their pain and of their need for medications." They continued to experience pain despite reassurance from the physicians that they had none. By their refusal to accept the labels "painfree," "hypochondriacal" and "demanding," these patients became "*adversaries* of the ward staff and of their physicians."

As early as 1890, Alice James wrote of the dehumanizing effects created by interaction with a physician: "I suppose one has a greater sense of intellectual degradation after an interview with a doctor than from any human experience." These same feelings may have been shared by a woman casually described in the *New England Journal of Medicine* report: "While being interviewed by the house officer, she suddenly jumped through an open window."

A man developing a serious complication "probably due to his medications" became "*delusional* and expressed the belief that the hospital was contaminated. His usual *dependent, obsequious* manner changed suddenly to open anger at his doctors." The physicians obviously preferred the patient's previous manner of behavior despite the fact that his anger seems to reflect a more healthy response toward the nature of medical treatment he was receiving.

Another patient refused to be placed on an artificial kidney machine. "*When his angry protests were ignored*, he made cuts around his shunt with a razor blade."

Upon discovering that her drug treatment program was not working, a woman with myeloma "*was told* that radiotherapy was to be started." She subsequently became "resistant . . . she struggled with them when they attempted to take her to the radiotherapy department." *She was told* strongly suggests that she was given no choice. When she chose to choose she was labeled "resistant," "angry" and "accusatory."

Perhaps the most insightful statement made by the authors of this study was that "each suicide attempt was associated with

anger." This insight does not seem to include any understanding as to what or who precipitated or exacerbated the anger. Instead the authors conclude by describing the suicide attempts as disturbances of "impulse control."

MEDICALIZED VERSUS HEALTHY SOCIETY

Ours is an age which consciously pursues health, and yet only believes in the reality of sickness.—Susan Sontag

Galdston believes that modern medicine has failed, not because it has "no cure for cancer, for essential hypertension, or for multiple sclerosis. Were it to achieve these and other cures besides, it still would have failed." This failure is due to the fact that "modern medicine is almost entirely preoccupied with diseases and their treatment, and very little, if at all, with health."[26(p2)]

These observations seem tame, for they fail to indict the medical profession for the misuse of the knowledge and skills it has acquired, for keeping the secret cited by Dr. Lewis Thomas "that most things get better by themselves . . . (and) much of human illness is self-limiting and spontaneously reversible,"[27] for failing to acknowledge that the power to heal resides in the individual, for grossly exaggerating what the profession can do (e.g., bring back to life), and for fostering fragmentation and vulnerability, which serve to undermine the power and autonomy of the individual.

It becomes increasingly clear that a medicalized society (which spends more than $120 billion a year on health) is not a healthy society. The counterproductivity of the medical profession is only one aspect of living in a death-engendering society, and the toll is taken not only in lives but in ecological integrity.

A renaming of the agents of disease is imperative as is a reclaiming of the life instincts that foster health: a health nourished by the environmental and social factors that advance thought and creative effort; a health that springs from the restoration of the normal, balanced rhythms of life.

BREAKING THE SILENCE

The only people who really know *anything about medical science are the nurses, and they never tell.*—Djuna Barnes

A sense that many nurses are committed to providing quality nursing care does not cancel out the necessity of examining the role of nurses in the masking or perpetuating of iatrogenesis. Nurses may find themselves living out what Woolf has described as "unreal loyalties" to the medical model, the hospital, the physicians, etc.[14] Unreal loyalties underlie (1) acting as an advocate for the physician and not the patient; (2) taking personal offense to patients' rebellion against oppressive hospital agendas; (3) justifying harmful or unnecessary procedures out of a fear of legal reprisal; and (4) participating in the erasure of physicians' errors and inadequacies.

When nurses recognize the incompetence of a particular physician, they often discuss among themselves how they would never have this physician treat anyone they care about, but they do nothing to see that the physician does not continue to "take

care of" countless others. When they do take measures to report what they find unconscionable, they are often merely placated because they do not go outside of the system with their information and concerns. Loyalties to the institution and the physicians take precedence over a basic sense of loyalty to the self and the person being cared for.

Another trap is that of token torturer. "The nurse . . . functions as a token torturer in the primary sense of the term *token*, that is, as an outward indication or expression. She is both weapon and shield for the divine doctor in his warfare against The Enemy, Disease, to which the women [sic] patient is susceptible by her nature."[16(p277)] The role of token torturer is expressed in part by witnessing and/or participating in unnecessary or harmful treatments or surgery and by administering health-damaging drugs.

By attempting to take refuge in the ready-made values of the medical world, nurses validate these ready-made values while negating their own potential as healers. By acting out unreal loyalties, or as token torturers, nurses become alienated from their own sense of integrity, which is the true source of healing ability. Each time nurses remain silent, when they know the silence should be broken, they sacrifice their own personal power and reinforce the syndrome of necrophilia and iatrogenesis. There are nurses who fight against falling into these traps, but the system is such that it facilitates and rewards not seeing, not hearing, not speaking and not acting.

By acting out unreal loyalties, or as token torturers, nurses become alienated from their own sense of integrity, which is the true source of healing ability.

An analysis of the present health care system is fraught with ambiguities. It becomes, however, increasingly more evident and more urgent that nurses break the silence and break out of the system. Nurses must begin removing their energies and healing powers from the medical profession, where they are drained and distorted, and must begin to rechannel them into envisioning and creating biophilic health care.

As Crones/Furies find again our new and ancient wisdom and psychic power, we can communicate the gynergy that will save our sisters from being captured and killed. This creation of Self-identified sense of reality is our most potent safeguard against the mind/body violators who offer the "gift of peace" at the price of living death.[16(p292)]

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