



Is Man Free To Make Choices for Health?

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When considering the problem of man's freedom, Eric Fromm has asked, "Is man free to choose the good at any given moment or has he no such freedom of choice because he is determined by forces inside and outside himself?"

My own answers to this must be couched in somewhat qualified and obscure terms, for in reaching conclusions it is necessary to consider the category of youth to whom reference is made. For the "average" middle-class or middle-income youth in our nation, the range of choices regarding health matters, as in many other areas, is wide indeed. He and his family have continuous access to perhaps the best medical care system which the world has produced. His value system has been carefully nurtured throughout his lifetime, beginning with good prenatal and obstetrical care of his mother. He has grown up in fresh air, sunshine and pleasing sanitary surroundings, accompanied by adequate nutrition, proper rest, excellent recreation facilities and culturally enriching experiences. (In school he sat on the side of the classroom which used "Crest.") To a significant extent, therefore, his values and choices in health are quite personal ones, guided by the most advanced knowledge and consultation available and with a tremendous range of

discretion and freedom as to his personal pursuits and health habit patterns.

The extent to which this model extends to the majority of our population, however, is unknown. There appears to be overwhelming evidence that this pattern, in gross terms, is far more atypical than we would suspect. I should propose that we examine three or four major aspects of the situation. These have to do with the overall delivery of the health care system, continuing poverty of a sizeable portion of our population, what we may term the "network" of health and health-related pathologies, and the large problem of communication of values.

I pursue this approach because, to paraphrase William Menninger, a human being must be seen as a totality, and sooner or later his family, community, work, upbringing, physiology, biochemistry, pathology and residuals of early disease and experience must be taken into account. Obviously, in dealing with the health of the human being in his family or community context, it is necessary that numerous disciplines work together in coordinated fashion because the man himself must be seen as a whole man.

THE HEALTH CARE DELIVERY SYSTEM

In looking at the health care system in our nation for the population at large, there

are problems of fragmentation: medical services must be shopped for and can be found only in little pieces and segments. This has resulted in medical care services which are not comprehensive but are narrow and limited; even in concept they are not designed to cope or to be concerned with looking at the total problems of the total person. We have also created problems where health care services are not continuous, because of the multiple organizational structures which have evolved. In addition, health care services have been developed which are all too often of poor quality. Dr. John Philp has said that, "there follows an obvious need to completely restructure and repackage our system of providing health care. Our new package and structure must be a system which will eliminate the fragmentation, which will provide comprehensive care for the total problems of the total person, which is continuous, which is of high quality, and which is family centered." Furthermore, he asserts that, "the repackaging or the restructuring should be such as to eliminate the public sector of health care services and replace this with one level of health care services for all." Unmet needs in the field of mental health as related to youth form a particularly outstanding case in point. According to the study of the Joint Commission on Mental



Illness and Health, "there is not a single community in this country which provides an acceptable standard of services for its mentally ill children, running the spectrum from early therapeutic intervention to social restoration in the home, the school and the community." These difficulties are compounded by projected estimates of children and youth in the United States who will require treatment in the future. Dr. Morton Kramer of the National Institute for Mental Health predicts that between 1963 and 1973, increases of 164 percent and 70 percent are expected in the numbers of patients in the age groups under 15 years, and between 15-24, respectively.

Related data indicate that the more rural the community, the less available are facilities and most types of personnel with "medical and related competencies." It has been reported that children in isolated rural counties receive one-third less medical care than those in and near cities. The mortality rate of children aged 5-14 is 50 percent higher in rural than in urban areas; the rate for the 15-24-year-old rural group is double.

While in urban communities, a variety of outpatient mental health services often are provided by agencies such as family service and child welfare agencies, and school psychological services, in rural areas the psychiatric clinic frequently is the only mental health resource available. The monumental work of NIMH, *Mental Health in Appalachia*, depicts certain of the direst aspects of the problems in this region in graphic detail:

There are mental hospitals in rural Appalachia, but the hospital may be separated from the person who needs treatment by 150 miles, where roads are few at best and nonexistent in many places.... When a psychiatric social worker actually has to climb to the top of a slate dump to find a small community in need of assistance, the time involved makes it impossible for her to help very many people that day.

This report notes further that in the Appalachian area there is a higher percentage of childhood disability cases—mentally retarded children or seriously handicapped

children than in any other section of the country in relation to population, and the complexities of providing care for children and youth are many. There are inadequate services for a child's hearing and eyesight; thus some children are being classified as mentally retarded who may not be. There are also those who are so socially deprived that their progress is far slower than it would be if opportunities for educational experiences and contact with other children and youth were available.

Therefore, the freedom of youth to make choices and establish value systems is limited by mounting unmet needs associated with an absence or inadequacy of preventive, ameliorative, or rehabilitative health services. As a result, our nation has phenomenally high rates of infant mortality, malnutrition, birth defects, juvenile crime, emotional illness, chronicity and physical impairment, among other problems.

Estimates are that of some 50 million Americans who have physical, intellectual, or emotional handicaps which to varying degrees limit their ability to carry on major life functions, approximately 13.5 million are children and youth. Of the approximately 39 million Americans who have chronic or permanent defects resulting from disease, injury, or congenital malformations, some 6.5 million are under age 24. A Senate committee has estimated that 10 percent of our public school children are emotionally disturbed and in need of psychiatric guidance. Selective Service statistics reveal a significant incidence of handicapping conditions in males, aged 18-26, suggesting that if the entire male population of draft age were examined, approximately one-third would be disqualified for military service. Hearing, language and speech disorders are estimated to occur in over 15 percent of our population under 21. Also, approximately 22 percent of the clients served under vocational rehabilitation programs are under age 20.

The seriousness of the situation may be seen in Dr. Henry Silver's observations that "between 20 percent and 40 percent of all children suffer from one or more chronic conditions. And about 30 percent of these

handicapping conditions could be prevented or corrected by comprehensive care during the first five years of life; comprehensive care which was continued to age of 18 would prevent or correct 60 percent." I would assert therefore that freedom of choice in health largely has been usurped for the millions of children and youth in our nation who suffer handicapping conditions which could have been prevented, or where irreversible damage has occurred through failure to provide requisite services at the proper time. Their parents and our society have erred twice: by omission and by commission,

CONTINUING POVERTY

A similar case also can be made for the 12 to 15 million children and youth who continue to live in poverty. It is axiomatic that the numbers of children and youth who are chronically handicapped are markedly greater among the poor than in the rest of the population. These differences are exacerbated by developing trends which project that in 1970 nearly one-third of children in cities will be in families in the low-income bracket, and four out of five children on farms will be in low-income families. Poverty, of course, is not a problem confined to one race, nor is it confined to urban areas. Two-thirds of the nation's poor, in fact, are white; only one-third live in central city slums. Neither is the problem confined to certain geographic areas; the people needing health, welfare and related services live in all sections of the country.

There are a number of observations which can be made in this context. First, social deprivation usually appears to result in health deprivation. Second, due to the isolation of lower class or minority groups, there is often a lack of knowledge or a nonscientific-orientation on their part to health and medical care, making it difficult for them to be reached with modern medical and public health measures. Third, the economics of the matter cannot be forgotten. For instance, a Negro youth in the United States today is more than three times as likely to be poor as is a white person, and is two to three times as likely to be unemployed.



Negro life expectancy invariably continues to be shorter than that of the white population; the maternal mortality rate for Negroes continues to be from three to four times higher; and, for most causes of death, the rates continue to exceed those of whites. The ability to make value choices on the part of these youth groups indubitably must include factors such as the availability of medicine, education, welfare and economic support.

Neither do we need to look very far for numerous other conditions directly affecting the lives of many of our youth. Many variables complicate their search for identity and for values which are basic to making optimal choices for health. There are certain socioeconomic and psychological conditions which, by their very nature, inhibit or prevent youth from making appropriate health choices. Many of these circumstances often preclude the possibility of securing health care, even though the youth has decided he wants and needs to visit a medical facility. The range of possible choices frequently is limited by such considerations as transportation costs, clinic fees, cost of medicine, personal embarrassment, or the loss of dignity. At the heart of the matter are implications for major overhaul of the system of health care delivery to overcome persistent barriers and obstacles. There is little question that the ways in which youth perceive their needs, as well as their perceptions of the possibilities for achieving them, in large measure determine their personal choices,

THE NETWORK OF CONTINUING HEALTH AND HEALTH-RELATED PATHOLOGIES

It is important to recognize that when family incomes fall below a minimum that provides enough money for food, clothing, shelter and transportation, many children and youth, as well as their parents, are unable either to derive benefit from existing health, education and counseling services, or make optimal choices. It is from this complex of difficulties, particularly among our nation's minority groups and the poor in urban ghettos, as well as in rural, isolated byways, that our systems of welfare assistance, health care

and education have come under sharp and mounting criticism.

The current climate and circumstances for youth to develop adequate value systems and make optimal choices is far from ideal. This is a time when our nation is suffering from an array of disruptive influences. Numerous studies show that in every large city there are well-defined areas with the highest indexes of all social disorders, irrespective of the ethnic identification of the inhabitants. It is well known that these settings include high concentrations of minority groups and the poor, high rates of alcoholism and drug abuse, widespread family disruption, high rates of economic dependency, illegitimacy, high infant mortality rates, and large-scale housing and neighborhood obsolescence. These areas also reflect the invasion of crime and racketeering among other conditions.

The network of continuing personal and social pathologies associated with or growing out of these conditions is legion. Consider the following examples:

1. There are thousands of children in all our big cities for whom the provision of warmth and emotional security and response, buttressed by financial security so essential for nurturing, has been and continues to be a near impossibility, due to the inability of their parents to surmount incapacities and handicaps.

2. Many children have personal histories of abuse, neglect, abandonment, exploitation, or being unwanted; many are illegitimate. For some, these experiences have resulted in such degrees of trauma that they ward off involvement with other humans. Some have been described as being "immunized" and "insulated" in relation to the normal range of affectionate interpersonal responses.

3. In addition, there are a great number of children and youth whose intellectual potential and personal creative capabilities are never realized, for they have been unreached or their needs have been unmet through the schools and other societal institutions.

To a degree, these conditions are directly related to: (a) high communicable disease rates (such as those for tuberculosis, venereal

diseases and gastrointestinal disorders); (b) high rates of emotional impairment; (c) nutritional deficiencies; (d) disproportionately high rates of chronic illness; and (e) high rates of accidents and fatalities.

THE COMMUNICATION OF VALUES

When working with others in the community, numerous considerations are involved, such as the necessity to become adept in understanding and interpreting value systems which often are different from those to which one ordinarily is accustomed. A large part of the task consists of reaching an understanding in regard to mutual expectations in various social situations. As important as it is to attempt to meet these needs, of comparable importance is the matter of the methods to be employed in meeting them. Approaches in providing lower income groups with health information and medical services must be formulated in terms which are meaningful to them.

Some of the health services and programs which must be brought to persons are only secondarily related to health concerns. It has been noted that the gap between traditional "middle-class" public health and medical care programs and "lower-class" culture, habits and expectations must be narrowed and bridged in the hope of increasing communication and cooperation. Communication is a "bridge-building" operation and successful upgrading of human beings can only be accomplished through a "do-with" partnership between needy groups and those who would help them. "Do-with" relationships mean that the main functions of the helpers are to stimulate, sustain and assist efforts toward self-help and self-development, a shoulder-to-shoulder effort in the neighborhood with the people who live there. Frequently, it is tiring and trying work, but is no more work as exciting or as personally rewarding? While it does not necessarily require special training, it does require such traits of character as a genuine interest in one's fellow man.

Psychoanalysis has introduced us to the concept that human beings are motivated to act to make choices-by unconscious as



well as conscious wishes, needs, or drives; that the ego has certain functions, such as memory, thinking, judgment and defense mechanisms. In addition, there is much talk now of the communication gap due to the generation gap. There is a different kind of communication gap, one which is due to a lack of education—of high quality teaching, quality recreation programs, and contact with the world outside the inner cities—and because many of our youth today cannot adequately communicate with the medical community or it with them. On the other hand, unfortunately, many other youth who are free to make choices, make the wrong ones. Witness the “drug scene,” which to a considerable extent is middle-class and college-linked.

[Are] youth free to make choices for health? Although there are many social deficits and physical and social pathologies affecting youth today, millions do have free choices, but it is clear that other millions have very little freedom of choice. This is not only in relation to health care, but also as regards education, recreation, employment, housing, nourishing food, adequate clothing, and the many other things that provide not only an absence of illness but a feeling of well-being, self-worth and completeness.

There are a number of implications for health workers, youth-serving groups, professional educators and recreationists. Basically, I believe that the adult world must assume increasing responsibility in all ways

possible for providing youth with guidelines for the development of lasting health values. In undertaking this task, increasing reliance must be placed upon skillful human relations and behavioral science insights and techniques. This means that values must be translated into meaningful and relevant terms for youth’s developmental and maturational processes. Because so many of our children and youth are growing up in a period of rapid and complex changes, and are exposed to greatly conflicting value choices, it is important that the possible consequences of certain choices be clearly defined. By no means does this effort at instruction and clarification imply moralizing, preaching, or dogmatizing, for if such approaches are used, the results may be the exact opposite of those deemed desirable.

It is my belief that activities designed to enhance feelings of security, self-worth and personal dignity are likely to be productive of optimal results. Teachers as well as other personnel serving youth in various ways can maximally utilize known and reliable techniques of self-discovery, personal motivation and identification with models of excellence in working with young people. As citizens, we bear responsibility to every community to see that the benefits of medical care services extend fully and with dignity to all who are in need of them.

We now know that the causes of many current human needs can be clearly identified and prevented. We know much about

how to meet numerous needs in advance of their points of crisis and during a crisis. We know much more than in the past about the makeup of communities, their structure, their dynamics, and the necessity and responsibility for all elements and agencies in the community to work together for the common good. We have learned much about the necessity for multidisciplinary approaches to problem-solving.

This is a large responsibility and it appears to fall more heavily upon our generation than upon any generation in the past. Among other persistent problems, our youth has grown up with the mushroom cloud and the ever-present threat of total annihilation. This generation apparently has been born to crisis.

In all of our efforts with youth, we must keep in the forefront of our minds that we are nurturing the future parents and leaders of tomorrow. We are dealing with human life and our nation’s most precious resource.

The 1970 White House Conference on Children and Youth is one of the means by which our nation can address itself to the myriad issues and problems in these and other critical problem areas. To the extent that we are successful in incorporating important values in health in our young, we help construct and set young lives on course, alleviating misery, extending the benefits of freedom to choose, and helping to ensure happy and wholesome communities.