# Health and Medicine in Transition

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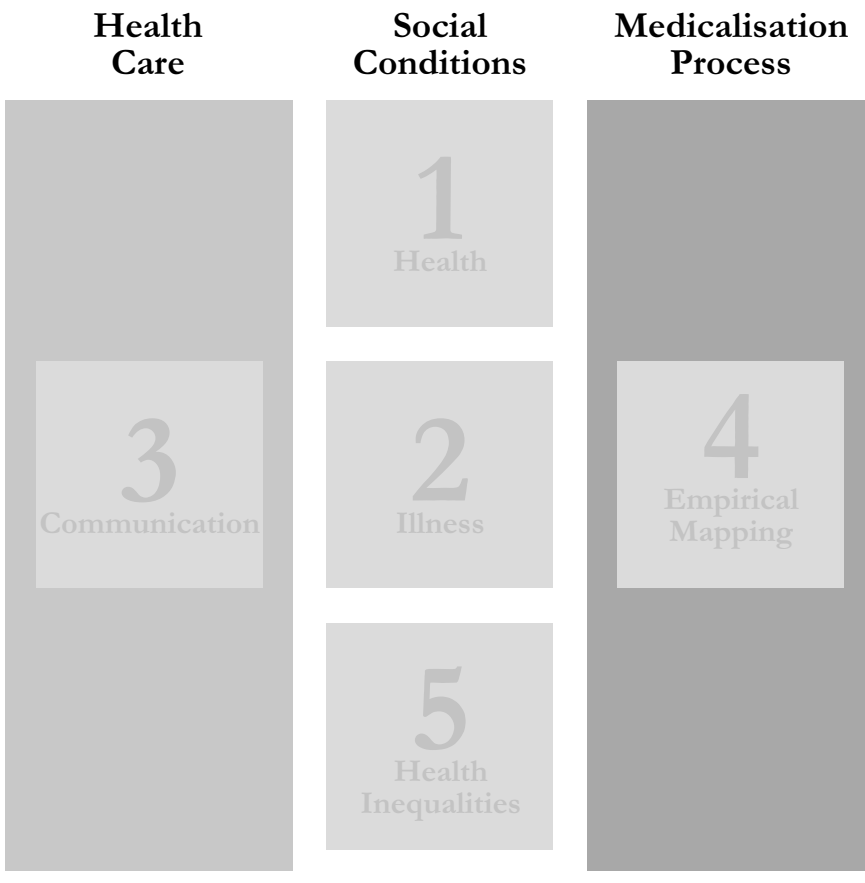

Modern medicine is one of the biggest achievements of the 20th century, among the strongest life-influencing factors in contemporary societies and a main reason that people are living longer and more active lives. It is also one of the largest industries and a source of many ethical controversies such as the question of patients' autonomy and integrity, the issues of unequal access, overmedication and similar. In today's societies, the discourse of science and expert knowledge lies at the heart of the dominant ideology and, as social scientists have pointed out, this is from where modern medicine draws its power. Being science-based, medicine is also believed to be close to the interests and values of the dominant social classes (*i.e.* knowledge classes), which tend to offer it generous support by subscribing to its ideology of healthy living and using its products and services.
However, analysts have also observed a growing disagreement between medicine and the ruling neoliberal capitalist system in Western societies. On one hand, modern medicine in general and doctors in particular have benefited enormously from the health insurance system and other welfare state programmes, as well as from the emergence of a mass market of health products. On the other, the work of medical professionals has become more and more controlled by actors in the public and private arena, such as governments and private companies. The pressures seem to be increasing from both sides. There is also a tendency in Western countries to rationalise health care, which is another development undermining the authority of modern medicine. In such an economic and political context, managers, economists and advertisers are competing with medical professionals for the role of the dominant experts who will define the optimal criteria for medical practice.
In this way, the boundaries of medical knowledge are increasingly being set by politics and capital, and not by the inherent logic of the medical profession and science, a process which may ultimately undermine medical knowledge itself (Coburn and Willis, 2000). The view that the power of medical professionals is based on the rarity and elitist nature of medical expertise rests on the assumption that, apart from some marginal parts, medical practice cannot be routinised and reproduced. What can be reproduced are technical procedures inherent to the medical practice, but not the knowledge, skills and experiences of doctors, it is assumed. In other words, the proportion of medical expertise that does not render itself easily to reproduction and routinisation will determine how much exclusivist power modern medicine still possess. As of late, some experts have observed that the development of the field of medicine is going in the direction of a greater possibility of routinisation and even concluded that medicine is being proletarised. The more technical medical practice becomes, the more its exclusiveness and prestige are reduced (Coburn and Willis, 2000).

It therefore seems that in the 21st century the growing influence of medicine observed in the last 100 years or so is being counterbalanced by various forms of its social dependence. As already noted, the big supervisor of the population's health practices is increasingly becoming supervised itself, particularly by governments, as well as health and social insurance systems. All of these players are becoming ever more involved in the financial aspects of health care, a process which brings about closer monitoring of medical professionals' work. In many respects, medicine seem to be losing its previously held position of an autonomous, self-sufficient system of health care, and its undisputed authority to draw the line between illness and normalcy. However, the fact that medicine has been pushed into a more dependent and less autonomous position precisely in the era of the sweeping medicalisation of modern societies is quite ironic.

Nevertheless, we should not lose sight of the fact that modern medicine still exercises an extremely strong influence over society. This influence is further empowered by structural factors such as the spread of chronic illness due to demographic shifts in Western societies, particularly longevity and the ageing of populations. Further, new approaches to healing promote the view that all of us are continuously at a health risk. Another source of its social visibility and presence in the public discourse are biomedical innovations and genetic technologies that generate new ethical dilemmas, visions and utopias about new forms of society.

Reflecting these diverse trends, the monograph will address various angles of the social role and influence of contemporary medicine. Chapter one provides an overview of the main theoretical concepts and debates, some of which are discussed in more detail in later sections. It depicts health as a largely social phenomenon and medicine as a social science, overviews the notions and concepts of health and illness, the cultural and ideological meanings of illness, including its use as a metaphor for social deviance, as well as the process of the medicalisation of everyday life. Using empirical evidence, it sets out to explore how deeply conceptions of health and illness are embedded in the social reality. Given that large sections of the adult population report regularly taking prescribed medications, the 'presence' of modern medicine in the day-to-day lives of people seems substantial, particularly in the context of the ageing population where medicine seems to have replaced religion as the primary resource that can 'alleviate' the onset of old age. In this context, the chapter discusses whether individuals today symbolically demonstrate their ability to establish control over themselves by assuming personal responsibility for own health, and whether by doing this they are relieved of the need to control the wider social events and conditions which are slipping through their fingers.

Chapter two narrows the focus to the social meaning of illness and the role of the medical profession and medical knowledge. It discusses medicine as a modern institution of social control, as well as models of relations between doctors and patients in the context of the highly imbalanced power distribution between them. Slovenian public opinion data is used to determine whether the high prestige of the occupation of doctor has survived the shifts in the social, economic and political system occurring during the period of transition, while international survey data is employed to explore the role and autonomy of patients and public perceptions of the doctor-patient relationship. It examines whether the partnership model of the doctor-patient relationship has established itself as the prevalent normative model in European countries and how widespread are the perceptions of the power dominance of doctors in their relationship with patients.

Chapter three further addresses the problem of asymmetric communication between doctor and patient, and discusses communication as a tool of treatment, particularly in relation to trust which is at the core of doctor-patient communication in health care. It explores public experiences and preferences with respect to the doctor-patient relationship, especially the presence of the underlying culture of 'awe' on the side of patients, demonstrated by their reluctance to ask doctors for information and doctors' unwillingness to discuss issues with them often enough, despite the ever more frequent propaganda of the 'service' character of modern medicine. It examines the paradox that the public has, on one hand, high trust in doctors' expertise, while at the same time considers views about the professional arrogance of doctors, a view most clearly embodied in the belief that doctors are unwilling to own up to their mistakes. Finally, it reviews public attitudes to some of the ethical dilemmas brought up by contemporary medicine like abortion, euthanasia and moral priorities in treating patients. Given that big shares of the public seem increasingly less reluctant to embrace unequal or discriminatory treatment of patients on moral grounds, the chapter speculates that medical professionals are likely to face ethical dilemmas even more strongly in the near future.

Chapter four is dedicated to a more extensive empirical analysis of medical norms and the process of medicalisation. Using European Social Survey data, it explores public attitudes to the use of prescribed medication, as well as attitudes to conventional and alternative medicine. It explores whether some health issues that were not traditionally medicalised are increasingly being so, either as a consequence of positive experience with doctors' treatment, or as part of the general medicalisation of respondents' health-related behaviour. It discusses how different sections of the public attach different ideological meanings to different (pseudo) health conditions and show much greater tolerance for the

use of medications that help enhance individual performance (into old age) or offer a remedy for conditions which are not the 'fault' of an individual, as opposed to those that simply increase an individual's fun or compensates for their 'sloppiness' or lack of effort. In the light of these findings, the chapter emphasises how health-based functionality is an extremely valuable asset in an ageing society and how it fits well into the ideology of 'self-maintenance', productivity and achievement. Detecting strong elements of realism and scepticism in public attitudes to the efficiency of complementary and alternative medicine, the chapter asserts that scientific medicine remains by far the most widely used choice to address serious health issues.

Chapter five maintains the empirical focus. It draws on time series data from the Slovenian Public Opinion Survey to investigate the prominent topic of social determinants of health inequalities, taking Slovenia as an analytical case. It explores the hypothesis that, due to persistent structural inequalities in education, income and social risks, the scope of social inequalities in health also persists. In light of the fact that public health systems were established to guarantee every citizen equal access to health care and to separate the issue of an individual's health from issues of material well-being, the chapter examines how successful the welfare system in Slovenia was in achieving this goal over the last three decades, *i.e.* to what extent are social and gender inequalities in Slovenia being reproduced as health inequalities. Using self-assessed health as the key empirical indicator, it discusses health (in)security and the fear of the disintegration of the public health care system, cautioning that the dismantling of existing health care arrangements may result in short-term financial gains but is likely to trigger long-lasting negative consequences for public health, especially for vulnerable groups like women.

In addition to providing an empirically informed overview of contemporary theoretical debates for interested scholars and students, another of the book's contributions is that it brings to wider attention the 30-year-long Slovenian time-series of health indicators. It is quite a rarity to be able to examine subjective health trends in the context of two political systems and observe how this relationship is affected by major episodes of social stress and economic crises. A somewhat similar case is the use of the so far largely overlooked European Social Survey Round 2 Health Module to examine public attitudes to recreational use of prescribed medication across a range of European countries. The findings may be of interest to researchers interested in issues of class or gender-specific medical norms, the medicalisation of everyday life, or the social impact of the pharmaceutical paradigm and industry.

# 1 Health as a Social Phenomenon, Medicine as a Social Science

A paradoxical attitude to illness and health as well as to the institutions engaged in preserving health, preventing and treating illness has characterised Western societies in recent decades. People's dependence on biomedical science, which is to provide answers to the growing social and health problems, is growing. There is an increasing number of phenomena we identify as a clinical (health) problem and disorder. There are also more and more discussions about unhealthy life and people's unhealthy life habits; these range from unhealthy relationships to unhealthy food, unhealthy leisure activities to unhealthy clothing, and from sexuality to the physical training of bodies. The list of everyday activities related to health is always growing. Medical discourse on health, illness and body dominates both public and private speech. We encounter the medical rhetoric and evidence in many public debates and political campaigns.

In addition to medicine expanding its jurisdiction to ever new problems, or that doctors are professionally committed to the search for diseases, or that society is trying to contain the emergence of certain illness, the real issue is that medicine is widely and ever more engaged in how to plan, act and live our lives. What is more, health is becoming a greater value for all categories of the population, from children to the elderly. At the same time, the attitude to official medicine is changing; from unconditional to only conditional trust or even doubt. More and more people are discovering and seeking help in a variety of traditional or alternative forms of healing practices. The commercial attitude to health services is expanding to medicine. Patients are becoming more equal users of medical services who assess the value of these services and critically react to any irregularities in the health system.

Medicine is also becoming increasingly expensive for both the state and the citizens. All major difficulties with financing the health system are on one hand a reflection of the rising technical sophistication of medicine. With demographic changes and ageing of the population in Western societies, the importance of medicine in everyday life is also increasing and so are the health costs for the state. The demographic transition from the dominance of younger generations in the previous century towards the gradual dominance of older generations in the future in the Western world including in our country also means the population's ever greater dependence on medicine. If young people are typically the most vital and most healthy part of the population that is the least dependent on health care, old age is on the contrary understood as a time of gradual degeneration and increased risks of illness. In short, the elderly are the major social group which is in the domain of medicine.

Population ageing is also changing the map of the main medical fields, themes and ideologies. Namely, another outcome of the ageing population is an increase in diseases specific to the elderly; diabetes, cancer, Alzheimer's and Parkinson's

disease etc., which are typically difficult to cure, and whose treatment is long and demanding. The attention of both the public and medical experts is thus increasingly shifting towards the new social-medical issues posed by the ageing of the population. However, since our lives, desires and values are still dominated by the cult of youth, we also try to reach youthfulness with the help of medicine, plastic surgery, cosmetic surgery, diets, medical practices etc. This, however, is further extending the field and practice of medicine.

Another important factor in the social development of medicine is the growing dependence of medicine on legal regulations and norms. Under the pressure of legally based threats, so-called defensive medicine is being rapidly implemented in the Western world; such medicine has a tendency for the excessive use of diagnostics and therapy just to protect doctors from potential lawsuits due to errors or unforeseen consequences of treatment. We can say that today in many places the law has been incorporated into medical ethics, or even that medical law is taking the place of medical ethics.

Further, a growing number of other institutions is intervening in the field of medicine: government departments, ministries, parliament, legal services, social security, insurance companies, ombudsmen, ethics committees, scientific research institutions etc. This means that medicine itself is no longer a 'sovereign' ruler of its own field. It has to act in a parliamentary and not a royalist manner. It must accept an equal footing with the other institutions, agencies, social roles, knowledge and practices; the most important reason for this is that medicine is also expanding in the field of maintaining the health and not only treating illness. There is nothing wrong if the medical field's ambition is to extend from the medical treatment of illness to preserving health. What is problematic, however, is if medicine imposes itself as a hegemon, that is, as a 'subject who knows'. Here medicine meets the borderline fields of other sciences and knowledge. Precisely the entry into the field of maintaining health means that medicine is entering an interdisciplinary field where any ambition attempting to present its own professional paradigm as the only true or appropriate paradigm might shatter. Anyone in such a field who would try to impose their own knowledge as a universal wisdom could risk a large amount of resistance and people's even greater recourse to paramedical, alternative practices and patterns of thinking, as are otherwise known or usual in modern societies.

There are already so many dilemmas in the attitude to health, illness and the prevailing scientific-technical model of medicine which are also so strong that they are already undermining the relationships between patients and doctors. What then is left to medicine in such a situation? Its completion with that part of medical practice which cannot be replaced by any other technique has been pushed aside in the process of the 'technisation' and 'scientification' of medicine.

Here, however, medicine needs more cooperation with other disciplines, especially social ones. The sociology of medicine extends the problem of illness and patient and moves from the questions of symptoms and signs of illness and coping with them to the questions of why people get ill in the first place and then stay ill. Such an approach to the patient and illness opens up a whole new range of dilemmas: societal, social and those related to identity and values. If we want to understand these dilemmas, we must address an analysis of the manners of everyday life, its practices, relationships, satisfactions and dissatisfactions. In such contexts, illness itself gains a whole new meaning and significance.

Developments and changes in contemporary medicine can therefore only be understood if we grasp them in the context of social transformations. Medicine will have to come to the realisation that it is fully embedded in modern society and that the boundary between scientific medicine and society, which previously allowed that the problems of medicine were solved exclusively within the medical profession, has been blurred. The problems medicine is facing today cannot be solved without interaction and cooperation with other disciplines, particularly the social sciences.

## 1.1 Development of the Notions of Illness and Health

While the notion of health encompasses a very wide spectrum of life experiences and practices, the notion of illness is restricted to signify the opposition to health. And yet health is an undefined category, an unmarked field, unlike illnesses which are labelled and structured. A whole range of experts, researchers and practitioners is engaged with their definitions, symptoms, causes and consequences. Illness is therefore the one we are consciously dealing with. However, this is becoming less and less true as we are increasingly dealing with health in both everyday life and science. Health and health promotion are becoming ever more important areas of everyday activities, public life and scientific research; for example, the ways of preserving health and the quality of life related to health, analyses of everyday practices that maintain health and well-being such as dietary practices, body care, quality interpersonal relationships, job satisfaction and self-esteem.

Due to the diversity of comprehensions of health and illness it is better to speak about the 'histories' of each of the two notions than about one common 'history' of the two notions at the same time. In pre-modern (traditional) societies both concepts were closely linked with religious conceptions, for example of cleanliness and filthiness or danger. Primitive notions of taboo and filthiness were not 'hygienic' notions because at that time there was no medical concept of hygiene. Further, the prescriptions of diets in the Scriptures are prescriptions

on religious and not health behaviour. Religious conceptions of health focused more on the health of the soul than on the health of the body (Turner, 2000). According to these conceptions, people are sick because they violate certain social norms and taboos that distinguish the sacred from the profane. Often the causes of illness were attributed to the influences of evil forces, witchcraft or possession by demons.

Such a conception of illness was part of a general mythical cosmology of good and evil forces and the justification of every accident or illness with a certain imbalance in the proportions between these forces or with the conflict of these forces. Typical questioning about the cause of a disease was *"Why is it that precisely I got ill?"* and not *"What is the cause of this disease?"*. Similarly, the answers to this question were also distinctly related to one's personality; they searched for the causes and interpreted the disease as the individual's fault or responsibility. Accordingly, the recommended or required 'therapy' usually consisted of an attempt to remove or reduce the individual's guilt for the disease.

In ancient Greek medicine, secular concepts of health, disease and medicine also began to emerge alongside religious and mythical concepts of both notions. The concept of 'balance' between the different components of the human body, which was so important for the development of early medicine in Antiquity, was therefore a heritage of older mythological notions of healthy and diseased people and had an empirical-philosophical explanation. Bryan S. Turner also points out the contradictions between the individualistic and socio-collectivistic understanding of Greek medicine or the contradiction between the 'panacean' and 'hygienic' concepts of medicine. While the hygienic approach was based on prevention and community care for the lifestyle of patients, the panacean approach was based on medical interventions in patients, the use of medicines and the like (Turner, 2000). We can thus see how all models of health and illness, together with all their fundamental contradictions, that we know of today already started to emerge in Antiquity.

The notions of health and illness from the period of Antiquity were followed by the Judeo-Christian conceptions, which have always also been very ambivalent. On one hand, the idea of illness as a divine punishment for human sinfulness (especially in relation to sexuality and women's diseases) prevailed while, on the other, the conception of illness as an opportunity to redeem for one's sins through suffering emerged. Health care, therefore, was not essential in this context; more important was the concern for the soul and salvation. Only later did Christian churches also adopt care of the body and this in relation to various religious rites. Namely, although we have to take on the inevitability of suffering that disease brings, the concern to heal is also allowed. Nonetheless, the outcome of the treatment still mainly depended on the will of God and less

on the skills of doctors. Disease was understood as a trauma, which points to our sinfulness, but was also considered as an opportunity for a deeper spiritual insight and knowledge. Disease was thus both a penalty and a gift from God. This ambivalence has remained permanently inscribed in the Christian conception of illness.

The image of medicine in the Christian world was strongly influenced by the Christian patriarchate, which had further strengthened the patriarchal tendencies of Antique medicine. The first hospitals in the Christian world were 'hospices', houses where they cared for the poor and the sick, especially sick pilgrims (Foucault, 1975). In times of the mass epidemics, they took care of quarantine arrangements. Subsequent commercialisation of sinfulness and indulgences also involved illness in the network of monetary exchanges. Patients were thus required to pay for both the indulgences and treatment at the same time. It is no wonder then that people still attributed the causes of disease to the will of God and did not really try to resist illness.

It was not until the Reformation period that the individual relationship of the individual to their sinfulness as well as to their illness was introduced. This change affected the increased feelings of individual responsibility for risky behaviours and reinforced feelings of insecurity due to such personal responsibility. All of this accelerated the erosion of medieval conceptions of disease and medicine and contributed to the emergence of the scientific revolution in the 17$^{th}$ century. In the period from the 17$^{th}$ to the 19$^{th}$ century, the majority of ideologies, discourses and practices that frame modern biomedicine had developed. In this period, medicine rejected the 'superstitions' and submitted itself to utilitarianism and pragmatism as well as to faith in science and technics. Health began to be increasingly seen as a phenomenon that depends on the individual's concerns and behaviours and illness as something that can be avoided, namely, as something that is largely the responsibility of humans themselves. Together with the development of scientific medicine, the belief in the progress of medical knowledge had also strengthened; it was believed that scientific medicine would one day fully understand the human body, identify the causes of all diseases, and perhaps also be able to treat them all. With the hope and trust of the people in scientific medicine, the power of doctors and status of the medical profession also grew. Nevertheless, for long periods doctors were still considered little more than merchants. Both were considered as 'dirty', the merchants because of the money and doctors because of the blood and sick, infected bodies.

The revolution in medicine that has taken place since the 17$^{th}$ century has therefore introduced individual responsibility for health and a rational and experimental ethos of medicine. In his radical search for certainty and clarity, Descartes gave primacy to reason over emotions and feelings, to the individual's mind over

the authorities and the demands of society. Western medicine has connected Cartesian rationalism and dualism of the body and soul with empiricism, resulting in the mechanistic, materialistic image of man or the human organism as a self-sustaining automaton. The image of God has been pushed aside; God is now conceived as the image of the Creator of nature and the initial editor of the world who no longer interferes in nature. Similarly, the soul is supposed to be responsible only for the beginning, to start the body machine, but then does not interfere with the continued operation of this machine.

The development of medicine in the 19th century was strongly influenced by the contradictions between the individualistic and social models of health and medicine. On one side, there was the increasingly developed individualistically-oriented allopathic medicine, which achieved great success in individual treatment, the usage of new drugs, surgery and various forms of hospital treatment. On the other, new models of public health and social medicine emerged at the same time, which are considered as the beginnings of the concern to establish standards of public hygiene, defences against epidemics, concern for a healthy environment, health education of the masses etc. In this sense, medicine was socially critical as it pointed out the poor living conditions of the deprived population and the health-related consequences of poor living conditions in deprived parts of emerging cities. Questions began to emerge, such as whether to fight against tuberculosis primarily through mass vaccination of the population, or by improving the social and material conditions of life; both the public and the medical profession dealt extensively with these issues. The 19th century thus produced monumental social achievements in the improvement of living standards, hygiene standards and health care of all people, including the poor population. At the same time, medical education and training advanced along with the professionalism of medical staff.

With the advent of powerful modern European countries, the influence of medicine expanded from the patient to the country level. The state had tried to ensure the overall health of the population and, in order to achieve that, it strongly relied on medicine and left the public health concerns to it. Further, the notion of medical standards also developed in the 19th century, and medicine had deviated from its originally social role and focused on individual medicine. Clinical methods allowed a classification of diseases based on symptoms and signs. The birth of the clinic enabled the control of many patients at once, the classification of their diseases and performing of more detailed medical examinations. At that time, a new medical discourse emerged focused on controlling the masses, not only individuals. An example is the notion of insanity, which served to control the poor, incompetent and excluded. The modern concept of mental illness was developed from this (Foucault, 1973).

Previously, madness had been associated with divine or demonic control over a person. Then it became a 'mental illness' and thus a technical medical term that distances itself from the traditional concepts of possession, violence or extreme innovation. While the traditional concept of madness did not exclude reason, the modern concept of mental illness does.

According to Foucault, the new concept of mental illness also demanded new controlling institutions (mental hospitals) and new disciplines such as psychiatry. Foucault associated the growth of these institutions with the parallel emergence of other institutions of surveillance like regulated asylums, shelters, forced workshops, general hospitals and prisons. Their common characteristic was a tendency towards full control. The ideal of such control was Bentham's model of a Panopticon, an institutional building allowing the central overview and control of all inmates. Foucault believed this was not an Enlightenment triumph of modern times over medieval darkness, but new and much more intense and general forms of discipline, control, punishment, and subordination to social strengths (Foucault, 1975). Modern understandings of illness and infections had become a solid part of a larger system of social discipline and control.

Thomas Szasz also drew attention to the role of psychiatry in the violation of human dignity and human rights. He warned about the dangers of medicalising various social deviations. The most drastic of them are examples where political opponents and dissidents were turned into psychiatric patients, and similarly in defining homosexuality as a mental illness (Szasz, 1970). In this way, both Foucault and Szasz exposed the questionability of the alleged neutrality and reliability of scientific methods and concepts in the management of human life as well as the dubiousness of the medicalisation of deviance. We have already given up the tendency of 19th century doctors to find a single determining cause of each disease. Illnesses have different causes acting together in the occurrence of disease states, which is why it is often impossible to treat the same disease with a single and unified intervention, but often requires a combination of several therapeutic interventions.

The 20th century was the time of the most extensive and profound changes in medicine as well as in the understanding of health and illness. Medical knowledge and medical power merged with each other. Allopathic medicine took on a leading role in medical practice and research and along with that demanding standards of medical education achieved in specific university institutions emerged. The individualist and secular view of illness and treatment has prevailed. Although in the 20th century allopathic medicine, based on scientific foundations, prevailed over irrational and magical systems of treatment, at the end of the 20th and at the start of the 21st century we are again witnessing a parallel

rise in criticism of allopathic medicine and a revitalisation of alternative forms of treatment and healing. Therefore, we cannot speak about the final triumph of allopathic medicine over the magical and irrational systems of healing. But we can certainly say that in modern society the religious context of medicine and science has disappeared and been replaced by a naturalistic-technical context.

## 1.2 Modern Conceptions of Illness and Health

The disintegration of traditional institutions in the process of modernisation is a social and manifest aspect of the deep-rooted process of the abandonment of religious, mythical-magical, organic-holistic and qualitative views of the world and of man, and their replacement with scientific, secular and instrumental-computable views. It is typical of modernity that it significantly increases the number of different life alternatives and options that offer success or social promotion to the individual. At the same time, it also increases the uncertainties, and risks of wrong choices and decisions. In traditional societies the life paths of the majority of people were fairly predictable and offered little real alternatives. It was only with industrialisation, with modern and faster traffic, and the enormous increase in the goods market and labour market that a wide range of options and choices for individuals, even for members of lower social classes, formed. At the same time, the spatial and social mobility of the population had increased. This process significantly changed the view of an individual about their own life, it changed their identity (Giddens, 1991; Gergen, 1991). The individual was no longer bound to a particular place of residence, set habits, rules of behaviour, or beliefs. Individuals started to experience life as 'an opportunity' which is offered and should be exploited as much as possible.

These changes are by no means only emancipatory, but have also brought some irreversible 'losses' that are upsetting. Distinct of especially late modernity are risks with serious consequences, such as ecological catastrophes of planetary proportions or emerging new forms of illnesses, which can like in times past obtain epidemic proportions. Although these risks are seemingly distant from the individual, they influence all of man's life possibilities (Beck and Beck-Gernsheim, 1994). Modern people are certainly not the first to strongly fear serious catastrophes. Eschatological visions were common in the Middle Ages, and also in some other cultures people were faced with great risks. However, these visions of threats then were different from today's awareness of the dire consequences of current risks.

Hence the shift in the value orientation of people in modern societies, which is observed in all opinion polls and surveys of values and life orientations in