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Too much medicine?

Almost certainly

Most doctors believe medicine to be a force for good. Why else would they have become doctors? Yet while all know medicine's power to harm individual patients and whole populations, presumably few would agree with Ivan Illich that "The medical establishment has become a major threat to health."[1] Many might, however, accept the concept of the health economist Alain Enthoven that increasing medical inputs will at some point become counterproductive and produce more harm than good. So where is that point, and might we have reached it already?

Readers of the *BMJ* voted in a poll for us to explore these questions in a theme issue of the *BMJ*, and this is that issue. Unsurprisingly, we reach no clear answers, but the questions deserve far more intense debate in a world where many countries are steadily increasing their investment in health care. Presumably no one wants to keep cutting back on education, the arts, scientific research, good food, travel, and much else as we spend more and more of our resources on an unwinnable battle against death, pain, and sickness—particularly if Illich is right that in doing so we destroy our humanity. And do we in the rich world want to keep developing increasingly expensive treatments that achieve marginal benefits when most in the developing world do not have the undoubted benefits that come with simple measures like sanitation, clean water, and immunisation?

Any consideration of the limits of medicine has to begin a quarter of a century ago with Illich, who has so far produced the most radical critique of modern—or industrialised—medicine.[1] His argument is in some ways simple. Death, pain, and sickness are part of being human. All cultures have developed means to help people cope with all three. Indeed, health can even be defined as being successful in coping with these realities. Modern medicine has unfortunately destroyed these cultural and individual capacities, launching instead an inhuman attempt to defeat death, pain, and sickness. It has sapped the will of the people to suffer reality. "People are conditioned to *get* things rather than to *do* them . . . They want to be taught, moved, treated, or guided rather than to learn, to heal, and to find their own way." The analysis is supported by Amartya Sen's data showing that the more a society spends on health care the more likely are its inhabitants to regard themselves as sick.[2]

Illich's critique may seem laughable, even offensive, to the doctor standing at the end of the bed of a seriously ill person. Should the patient be thrown out and told to cope? It is of course much easier to offer a critique of cultures than to create new ones—and Illich (like doctors, ironically) is much stronger on diagnosis than cure. But he does write about recovering the ability for mutual self care and then learning to combine this with the use of modern technology. Though his polemic was published long before the internet, this most contemporary of technologies—combined with the move to patient partnership—is shifting power from doctors back to people. People may increasingly take charge, more consciously weighing the costs and benefits of the "medicalisation" of their lives. Armed with better information about the natural course of common conditions, they may more judiciously assess the real value of medicine's never ending regimen of tests and treatments.

Although some forces—the internet and patients' empowerment—might offer opportunities for "demedicalisation," many others encourage greater medicalisation. Patients and their professional advocacy groups can gain moral and financial benefit from having their condition defined as a disease.[3] Doctors, particularly some specialists, may welcome the boost to status, influence, and income that comes when new territory is defined as medical. Advances in genetics open up the possibility of defining almost all of us as sick, by diagnosing the "deficient" genes that predispose us to disease.[4] Global pharmaceutical companies have a clear interest in medicalising life's problems,[5 6] and there is now an ill for every pill.[7] Likewise companies manufacturing mammography equipment or tests for prostate specific antigen can grow rich on the medicalisation of risk.[8] Many journalists and editors still delight in mindless medical formulas, where fear mongering about the latest killer disease is accompanied by news of the latest wonder drug.[9] Governments may even welcome some of society's problems—within, for example, criminal justice—being redefined as medical, with the possibility of new solutions.

As the *BMJ*'s debate over "non-diseases" has shown, the concept of what is and what is not a disease is extremely slippery.[10 11] It is easy to create new diseases and new treatments, and many of life's normal processes—birth,[12] ageing,[13] sexuality,[14] unhappiness,[15] and death[16]—can be medicalised. Two sets of authors in the issue argue convincingly, however, that there is much undertreatment, suggesting a need for more medicalisation.[13 17] The challenge is to get the balance right.

It is those who pay for health care who might be expected to resist medicalisation, and governments, insurers, and employers have tried to restrain the rapid

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and unceasing growth in healthcare budgets. They have had little or no success, and Britain's government now plans to raise taxes to pay for more health care. Labour, the party in power, will have calculated that the risk of trying to bottle up demand is greater than the—substantial—risk of raising taxes. But while increased resources will be widely welcomed, the cost of trying to defeat death, pain, and sickness is unlimited, and beyond a certain point every penny spent may make the problem worse, eroding still further the human capacity to cope with reality.

Ivan Illich did not want the wholesale dismantling of medicine. He favoured "sanitation, inoculation, and vector control, well-distributed health education, healthy architecture, and safe machinery, general competence in first aid, equally distributed access to dental and primary medical care, as well as judiciously selected complex services."[1] These should be embedded within "a truly modern culture that fostered self-care and autonomy." This is a package that many doctors would find acceptable, particularly if available to everybody everywhere.

Doctors and their organisations understandably argue for increased spending—because they are otherwise left paying a personal price, trying to cope with increasing demand with inadequate resources. Indeed this is one of the sources of worldwide unhappiness among doctors.[18–20] Although seen by many as the perpetrators of medicalisation, doctors may actually be some of its most prominent victims.[3] This is perhaps why *BMJ* readers wanted this theme issue.

Perhaps some doctors will now become the pioneers of de-medicalisation. They can hand back power to patients, encourage self care and autonomy, call for better worldwide distribution of simple effective health care, resist the categorisation of life's problem as medical, promote the de-professionalisation of primary care, and help decide which complex services should be available. This is no longer a radical agenda.

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Health: perception versus observation

Self reported morbidity has severe limitations and can be extremely misleading

Critical scrutiny of public health care and medical strategy depends, among other things, on how individual states of health and illness are assessed. One of the complications in evaluating health states arises from the fact that a person's own understanding of his or her health may not accord with the appraisal of medical experts. More generally, there is a conceptual contrast between "internal" views of health (based on the patient's own perceptions) and "external" views (based on the observations of doctors or pathologists). Although the two views can certainly be combined (a good practitioner would be interested in both), major tension often exists between evaluations based respectively on the two perspectives.

The external view has come under considerable criticism recently, particularly from anthropological perspectives, for taking a distanced and less sensitive view of illness and health.[1 2] It has also been argued that public health decisions are quite often inadequately responsive to the patient's own understanding of suffering and healing. This type of criticism sometimes has much cogency, but in assessing this debate the severe limitations of the internal perspective must also be considered. Self reported morbidity is, in fact, already widely used as a part of social statistics, and a scrutiny of these statistics brings out difficulties that can thoroughly mislead public policy on health care and medical strategy.

For sensory assessment, the priority of the internal view can hardly be disputed—for example, pain is quintessentially a matter of self perception. If you feel pain, you do have pain, and if you do not feel pain, then no external observer can sensibly reject the view that you do not have pain. But medical practice is not concerned only with the sensory dimension of ill health. One problem with relying on the patient's own view of matters that are not entirely sensory lies in the fact that the patient's internal assessment may be seriously limited by his or her social experience. To take an extreme case, a person brought up in a community with a great many diseases and few medical facilities may be inclined to take certain symptoms as "normal" when they are clinically preventable.

Consider the different states of India, which have very diverse medical conditions, mortality rates, educational achievements, and so on. The state of Kerala has

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