

# Promotion of disease and corrosion of medicine

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Three intertwined and mutually reinforcing trends—the medicalization of life, the industrialization of health care, and the politicization of medicine—are actively promoting disease and fear of disease, while at the same time corroding the theory and practice of medicine. The discipline of general practice is well positioned to resist these trends and secure a better future.

## Medicalization of life

Global capitalist hegemony is opening up the whole arena of human health for the pursuit of profit, trading on human fear in an explicit and calculated manner. People living in the wealthy countries of the world are now living healthier and longer lives than ever before. Only a minority are sick, and so the profit to be made by developing and selling treatments for the sick is limited. There is much more money to be made by convincing the healthy majority of the immediacy of threats to their health and the need to take action to avert or minimize these threats.

An obsession with health is destructive of it.<sup>1</sup> The more people are exposed to the machinations of contemporary health care, the more they perceive themselves to be sick or at risk and the higher the rates of self-reported illness.<sup>2</sup> With the widespread expectation of a long and healthy life, fear is transmuted into greed and an ever-greater appetite for consuming health care resources at the expense of poorer and sicker people, both globally and locally. The largely unexamined conviction that “prevention is better than cure” provides a moral justification for the systematic diversion of health care resources from the sick to the healthy. The economic imperatives of the pharmaceutical industry drive the rhetoric and orchestrate ever-increasing demands for health care technologies.

Many research questions have simplistic linear structures, and results are extrapolated over

prolonged and unstudied periods, producing guidelines that overstate benefits to patients. At the same time, we have almost no understanding of the effects of being labeled as at increased risk.<sup>3</sup> The rhetoric of risk trades on the politics of responsibility, which creates an increasingly oppressive social obligation. We are encouraged to be afraid or ashamed of what we eat and drink and breathe, and to lead ever more regulated lives, devoid of thrills. But what is the point of eking out the longest possible life if there is no adventure in the living of it?

## Industrialization of health care

Market forces drive the standardization of goods and services in order to facilitate their free movement across borders. Reorganization of the delivery of health care has turned patients and doctors into standardized interchangeable units—cogs in the vast machinery of an industry.<sup>4</sup> The systematic deception is that medicine is simple, linear, and can be reduced to a series of robust guidelines and that there is a “right” answer in any given situation.

The implications of the industrialization of health care become even more disturbing as we shift from therapeutics to prevention. Unless epidemiology is firmly linked to basic science, causation is assumed rather than proven and correlation becomes confused with predictive value. Much current guidance seems to be built on this confusion.

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*This editorial is based on a paper presented by Dr Heath, who was awarded the 2005 Carl Moore Lectureship in Primary Care. The Lectureship is awarded annually by the Department of Family Medicine at McMaster University in Hamilton, Ont, to those who have made an important contribution to the understanding or development of primary care and are able to present a lecture that will engage, challenge, and be accessible to a general audience.*

The 2003 European Society of Cardiology guidelines suggest blood pressure above 140/90 mm Hg, with no age correction, and serum cholesterol of 5 mmol/L as the appropriate thresholds for interventions designed to lower the risk of ischemic heart disease. Norway has one of the highest life expectancies in the world, but if these thresholds are applied to the total population of a single Norwegian county,<sup>5</sup> half the population would be considered at risk by the early age of 24. By the age of 49, this proportion rises to 90%. Seventy-six percent of the total adult population would be considered at increased risk and identified as a potential market for preventive pharmaceuticals. What is happening? Three quarters of one of the world's healthiest populations are to be labeled at risk, and a shadow of doubt and fear is to be thrown over those otherwise healthy lives. In whose interests are these processes working?

### Politicization of medicine

Politicians must always put the needs of the population above those of the individual; clinicians must necessarily do the reverse. There is an inevitable conflict between societal fairness and sensitivity to individual need. Increasingly, in the laudable pursuit of equity, a utilitarian public health agenda is being actively imposed on the fragile good of the clinical encounter. Patients' needs extend far beyond the biomedical and are easily marginalized if the agenda of the consultation is dictated by outside forces. When political imperatives predominate, the political becomes concrete and people become abstract, diminished to units of political significance. Political history of the last century demonstrates how easily utilitarianism at a policy level can degenerate into the coercion of individuals. The current wave of coercion is directed at patients and professionals, as governments and policy makers seek to exert increasing control over the behaviour of both. To what extent are governments themselves being coerced by the economic power of multinational conglomerates?

Politicians have reason to be fearful of the long-established independence of professionals. Members of the traditional professions of teaching,

religion, law, and medicine are in daily contact with ordinary citizens and see first-hand how, how often, and to what extent society goes wrong. For each of these professions, this engagement carries responsibility and opportunity for advocacy and for interceding with the powerful on the part of the relatively powerless.<sup>6</sup> When the independence of these professions is eroded, as happens within totalitarian regimes and, increasingly, in contemporary market-driven societies, important elements of civil power and social justice are suppressed.

### Potential for resistance

Three factors give general practice the potential to resist the three related trends: first, the challenge and the freedom of uncertainty; second, the power of conversation in the delivery of care; and finally, the persistence of medical pluralism.

**Uncertainty.** Every day, GPs are confronted by the limitations of biomedical science and see how poorly the taxonomy of disease fits the lived experience of illness, suffering, and distress. General practitioners have a keener understanding of uncertainty than specialists because biomedical science is proportionately less robust in an unselected population with a low prevalence of serious disease.

All the freedom, challenge, and resilience of general practice are to be found in the gap between the map of medical science and the territory of illness and suffering.<sup>7</sup> In the gap, wisdom is more useful than information, and there is space for the exploration of "the key interests of the clinician: the exigent and difficult reality of illness as a human experience and the core relationships and tasks of clinical care."<sup>8</sup> In the relationship between doctor and patient, doctors hold the biomedical map and have a responsibility to have studied it well. The task of both doctor and patient is to explore the usefulness and the limitations of the map in relation to the territory of patients' illnesses.

**Conversation.** Norwegian GP John Nessa argues that "Doctors do an important job as conversationalists. This job is underestimated as part of medical work."<sup>9</sup> The conversation between doctor and

patient is where all the assumptions of biomedical science can be questioned and where ways must be found to make the generalizations of science useful to the predicament of a particular patient.

The outcome of conversation is always uncertain, and, if an authentic interaction is achieved, both parties become caught up and neither is in control. This unpredictability mirrors the uncertainty of the territory and resists the false certainty of medicalization, industrialization, and politicization. Stories of courage and endurance, achievement and health, can displace stories of failure and illness and so resist the medicalization of life. Continuing relationships between individual doctors and patients, the commitment of one person to another, can resist the industrialization of health care. Building alliances between patients and doctors, the coproduction of health (itself defined more broadly and more generously), and sharing information and explanations can resist the politicization of medicine.

**Pluralism.** General practice is increasingly subject to the forces of globalization, which seek to extend and exploit the map, but is also in daily contact with the local reality of the territory. General practice is embedded in a rich cultural and social context and invested with meaning by local communities.<sup>10</sup>

Lessons from medical anthropology suggest that the strength of this contextualized meaning could enable general practice to survive and to resist the pressures of globalization. The key concept is medical pluralism,<sup>11</sup> which has seen traditional medical systems in poorer countries not only survive but develop and thrive alongside Western scientific medicine. The assumption was that traditional systems would die out in the face of the success of Western medicine, but this has not happened; indeed, alternative systems have revived and flourished even in countries where scientific medicine is most highly developed and widely available.

Within traditional medical systems in Asia, "practitioners base their diagnosis and treatment on both abstract principles as well as embodied knowledge and guided sensibility and on ad hoc experimentation as well as formulations found in texts."<sup>11</sup>

And these are precisely the attributes of experienced GPs, who have to use skills and knowledge extending well beyond biomedical theory to negotiate the gap between the map and the territory for each patient. If GPs have meaning for their local communities, general practice might prove just as resistant to the standardization and reductionism of global economic forces as other local health care systems have been and might demonstrate an ability to hold and exploit the tension between traditional values and the forces of modernization and globalization.

Contrary to all expectation, pluralism and complementarity have become the norm across the world, which must give us good reason to be hopeful for the future thriving of general practice and an enduring resistance to the medicalization of life, the industrialization of health care, and the politicization of medicine. ✦

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