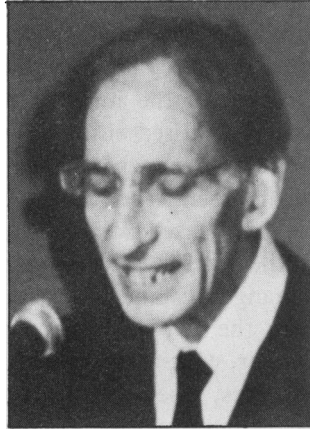


Medicalization and primary care*

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Introduction

YOU have invited a philosopher and historian to open this meeting of physicians. I am a total outsider in your company. The idea that I, rather than one of your colleagues or some other stranger—musician, lung surgeon or space traveller—should provide the initial attraction at your congress, amuses and challenges me. Please be patient with me as I try to explain what I mean by ‘medicalization’, why ‘de-medicalization’ seems to me a healthy procedure, and why I hold the paradoxical belief that general practitioners can contribute to this healthy process.

First allow me to introduce myself. I am, indeed, the author of *Medical Nemesis* (1975). Notwithstanding the title, I had no intention to make a contribution to medicine. When writing that book at no moment did I want to put the medical profession on trial. My purpose was that of describing and analysing a social phenomenon which by far transcends medicine, however you define that discipline and profession. In *Medical Nemesis* and *Limits to Medicine* (1976) I merely used the medical establishment of the early 'seventies as a coherent paradigm by which I could illustrate the same abstract analysis which I had documented seven, and then three years earlier by taking my examples from modern education and then from motorized transporta-

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tion. In all three instances, my task consisted in putting into a historian's perspective a contemporary phenomenon.

Not only education, transportation and, then, medicine were on trial in each case, but the institutional source of the popular wisdom that convinces most of my contemporaries that the services provided by these agencies correspond to basic human needs. Not the benefits provided by education, transportation or medicine, but the social arrangements which make these appear as desirable and necessary were my theme. Both as a historian and as a contemporary, it was important for me to clarify the recent, Western origin of our image of man, of *Homo educandus*, of *Homo transportandus*, of *Homo medicandus*. But this has not been an easy task. To project this image into the past veils what has really been. To hold it true for the present leads us to replace what I understand as Christian charity by the mask of love, which is institutional, professional care. Although neither medieval peasants, nor our great-grandparents, nor most contemporary indians in Mexico have the slightest perceived need for educational or medical provisions in the modern sense, most of the people who want to be your patients could not conceive of doing without either.

Making assumptions about your patients brings me from my own introduction to the analysis of my audience. I have prepared myself to speak to people who have gone through medical school, and who then have had the courage to choose so-called ‘general practice’. Today this option demands a positive choice. The motives for such a choice are many. However, I know several members of the younger generation who, in making this choice, had the clear intention to contribute to the de-medicalization of their patients' lives. I think of them, above all, when I speak to you.

What I have to offer are the reflections of the social philosopher on such a motivated choice. I would be happy indeed if, by providing the terms, I could sponsor a controversy among you: between those who have chosen general practice because they want to provide more encompassing, more total, more complete, more holistic care, and those others, probably a minority, who have chosen general practice to offer their patients the occasion to de-medicalize their own attitude to pain, disability, discomfort, ageing, birth and death.

The work of the contemporary general practitioner

While preparing this talk I asked myself: how would I, as a layman, speak to some real outsider about general practice in the 'eighties? How would I speak to a man from Mars, to St Hildegard of Bingen or to a physician of 120 years ago? Well, first I would say that the general practitioner today is always the graduate of a medical school, something which was not the rule in other ages and places. Then I would explain that general practitioners are the epitome of the service professional who developed out of clergy-organized pastoral care. They are trained to make a scientific diagnosis of each case that they treat; scientifically they must evaluate the physiological, psychological, social and environmental conditions of each of their patients—conditions about which they can do even less than the patients themselves. In the majority of cases the choice of a therapeutic procedure—be it effective, useless or dangerous—would have been the same without most of the diagnosis. Finally, I would explain to your pseudo-predecessor the three main categories into which the daily routines of the general practitioner can be placed: triage, policing and neo-pastoral care. These three functions intertwine, yet remain distinct.

Triage

Much of the general practitioner's time is obviously spent on triage. You are agents of referral to the clinical laboratory, to the specialist and the hospital administration. You certify the patient's entitlement to insurance, time off from work or clemency in court. Your diagnosis (which in Greek means discrimination) leads the patient into a hospital bed, to a blood test, from a workbench to a less stressful job, or to the inspection of his or her throat, anus or vagina by a colleague who uses a tool that you do not. Your scientific competence at classification places your patient on a new waiting line for service, rest, money, intervention. You might not like it, but many patients come to you as they go to the travel agent. And often, more in America than in England, your malpractice insurance forces you to give in to their pleas.

Policing

Another part of your job consists in guarding simple technical devices from unauthorized use. Probably quite correctly, our society makes the paradoxical assumption that its members—most likely because of their advanced education, their experience in dangerous living and driving, their daily contact with all kinds of poisons—are less suited than their forebearers to handle dangerous devices. Our society assumes that antibiotics, for instance, which can be packaged with precise instructions for their use and about contra-indications, should be kept out of people's hands—even though for millen-

nia the most dangerous poisons and addicting drugs (which were not titred and whose action was little understood) could stand on the kitchen shelf. Your licensing function as drug-police reflects and confirms a social regression. Further, we know from several studies that the treatment by the typical general practitioner of the typical patient consists in the prescription of a preparation that each doctor picks from an idiosyncratically assembled collection of no more than two dozen different drugs. If you say that your list comprises three dozen items, WHO tell me that you are an exception.

Triage by referral and the policing of prescriptions are only two of three fields of action that are characteristic for the modern general practitioner. Both could be understood by my own great-grandfathers Illich or Luxardo in the mid-nineteenth century, though both barely practised either. The barber in Dalmatia during the last century did not get his patients through referral by the doctor, and the prescriptions that the physician then dispensed were the same ones which my grandmother gave to the poor and the servants: they were just as dangerous and just as doubtfully appropriate. However, the third function of the modern general practitioner, which seemingly has changed least over the last centuries, does constitute something historically new. My great-grandparents could not have easily understood the patient relationship on which this third function builds. And often my physician friends overlook its essential feature. The newness of modern, personal care does not stem from what general practitioners do, or from the techniques they use, but from the kind of society within which they practise their age-old art, and the tie that only in this unique, modern society binds patients to their doctors.

Pastoral care

Traffic control within the medical system and the monopoly over drugs and techniques might provide general practitioners with money, but certainly do not give much satisfaction. This comes, if at all, from that third set of activities which I call general or pastoral care: you counsel people to take calcium lactate at bedtime, a drink before intercourse, or a brisk walk before work. You lead patients to replace the Valium prescribed by a colleague with camomile tea. You talk to them to make them give up cigarettes, to control their anger, or make them laugh at themselves when they overeat. In this logotherapy some of you observe the liturgy taught by the founder of their sect, others follow the stereotype of US executives, and others again let their healing personality envelop the patient. You spend your time to help the patient realize what or who is sickening for him or her. Perhaps you go further and listen to the patient; the sense of having found someone who listens for half an hour is the ingredient that then heals. However, there is no doubt that most of this care convinces the patients that whatever they themselves

have changed in their life-style they owe to you. Rather than being healthier, which always means being more autonomous, your client, through your care, becomes more dependent, more a patient. Most general care advances the medicalization of the patient's life. I wrote *Medical Nemesis* in order to analyse the ill-health paradox induced by this medicalization.

Medicalization

'Medicalization' is a neologism and not a beautiful term. I coined it because no old word fitted the twentieth-century reality of which I wanted to speak. I coined the term to describe the historical conditions under which the iatrogenic causation of ill-health is mediated through environmental and cultural transformations, rather than through pharmacological, surgical, radiological or psychotherapeutic treatments. Irving Zola, the medical sociologist from Brandeis, had employed the same term before me, with greater precision and in a similar way.

I speak of medicalization as one part of a historical process that disables ordinary people from caring for themselves, and makes them dependent on the provision of a service called care. I speak of the medicalization of health just as I speak about the motorization of personal locomotion. The motorization of traffic has deprived most people of the possibility of using their feet in a useful and beautiful way. The highways necessary for the vehicles separate people beyond the reach of their legs. Reliance on motors makes them neglect the use of their feet. Further, the new mobility available to a few people in seatbelts able to fly occasionally from Vienna to Dublin (as I irresponsibly just did), is advertised as such an important advance that it overshadows the damage it does to the cohesion of local communities, to the health of millions and to the environment. Medicalization, just like motorization, must be understood as an expression of a cultural pattern, not as the mere result of medical self-importance or greed. Medicalization, like motorization and compulsory schooling (Illich, 1971), are forms of social degradation through which dependence on service consumption is induced.

Medicalization occurs whenever some aspect of ordinary, everyday life comes to be so defined that it requires input from an institutionalized medical system. No doubt, just as motorization improves traffic from the standpoint of engineers and of the jet set, medicalization improves 'health' as defined by the medical system. No doubt, jet planes, like heart surgery, are potent points of sale for their respective systems. However, just as the motorization of locomotion inevitably entails the degradation of autonomous (or should I say 'healthy'?) locomotion, so the medicalization of health inevitably tends to degrade the art of living, of suffering and of dying, an art that has permitted thousands of unmedicalized cultures to cope with their reality. The medicalization of health care, therefore, no matter the

measurable changes of survival or morbidity rates that it confers, inevitably carries with it what I have called cultural iatrogenesis.

Cultural iatrogenesis is much easier to describe than it is to measure, which is one of the factors that distinguishes it from pharmaceutical side-effects. When I compare clinical side-effects with clinical benefits I compare two magnitudes that are of the same order. When, on the contrary, I compare the benefits of medicalization with its side-effect, namely the iatrogenic decline of the culturally supported ability to cope, I compare two profoundly different types of anthropological categories. What people gain is of another order of experience from that which they lose. They lose the personal ability to cope with reality as a result of their gain in health care. At present my research and writing concentrates mostly on this often neglected difference: the experience of satisfaction under the rule of traditionally gendered culture, and experience under the regime of care and scarcity.

Medicalizing birth

A good example to illustrate what I mean by the medicalization of health is the medicalization of birth. The various stages that led from the delivery of women within the gynaeceum to the delivery of children by the operation of a gynaeceological care system (Duden, 1982), are a paradigm of this process. There is no need to recount here the enormous variety of rituals and techniques and meanings that were associated with the delivery of women. Anthropologists tell us that no two cultures, in this respect, were alike. Certainly, in Western Europe up until 1770, delivery happened within the gynaeceum. Women helped each other. The language by which they described what they did clearly expressed what they were aiming at: to help the woman to 'unburden' her belly by delivery; to 'push' out the offspring, dead, monster, mooncalf or child. Typically she was expecting 'to be with child'—not 'pregnant', like a cow. Her neighbours, who had gone through it before, provided her with what she needed to push, to come down. The care of the infant—literally the non-speaker—was equally the women's affair, as was the decision that the infant should not survive. New historical research shows clearly that abortion, mainly in the form of infanticide by undernourishment, exposure or overlying, was a well-patterned part of the process of the mother's delivery, and remained so up into the nineteenth century and the onset of medicalized delivery in Europe.

During the last decades of the eighteenth century, the European nation states became concerned with the production of soldiers, the wealth of nations. Women were redefined as the producers of military and industrial armies. Consistent with the new nationalist ideologies, physicians entered the scene and provided the new language to redefine women's nature. Henceforth chil-

dren had to be delivered from their mothers' wombs, 'pulled' out by hook or by forceps. Birth, in the perspective of the physician, was no more an event that was allowed to happen among women, that is, among peers. It came to be seen as the function of a special organ that was carried around by women between their legs. Step by step women were redefined as a potential threat to childbirth, which became a function of a professional working at their wombs. Language and law both reflect this. First came the laws enacted on the assumption that women, if pregnant and poor and unwed, were a threat to the fruit of their wombs, potential murderesses. In Germany several laws of the 1790s required such women—under severe penalties—to register their pregnancy, to enable the medical police to monitor its results. The new laws were enacted just as the formal witchhunt subsided.

Then the law began to repress the gynaeceum. Assistance at birth by a trained and licensed midwife under medical control became compulsory, and the same law began to inveigh against peer assistants for those lying in. As in other domains, peers were degraded to laity. Through the midwife, the state assumed a new control over life. Within a couple of decades the hospitalization of single mothers became compulsory, better to protect their offspring from their murderous penchant and to command sufficient wombs as training materials for the doctor and midwife. As the nineteenth century advanced, the reasons given for hospitalization changed. The accent in medical literature shifted from the poor woman as a potential killer to the poor woman as an infectious agent. This was the epoch during which the organs, redefined as birth canals, were scrubbed with lysol and creosote. Only after the turn of the century—and this time under US leadership—did women at large demand for themselves the medicalization of delivery for which nineteenth-century prostitutes and the poor had provided the unwilling clinical model. Within another three generations the progress from the delivery of women by ordinary neighbours to the delivery of children by competent monopolists was completed—first through the universal hospitalization of birth, and then during the 1970s by the slow and gradual shift towards the medicalization of home-births. No doubt, during this inversion of birth, neonatal survival and, later, maternal survival increased—but at a cost of intense medicalization. What the doctor delivers is, tententiously, a life-long patient: a person dependent on care, who perhaps after long education will be able to sell care to others—but hardly a person free for neighbourly love.

Demedicalization

I have spoken about medicalization because, perhaps incorrectly, I believe that general practitioners under the British system are in a position to reverse it. They have an ambiguous function: they can either contribute

more effectively than the specialist to the further medicalization of life, or support the opposite trend. Neither technically nor culturally did this option exist for the general practitioner of the 'sixties. The ideology of the technical fix was still too deeply entrenched, and the prestige of the profession (no matter how much tainted by greed or pomp) was, then, not fundamentally at stake. At best individual, exceptional doctors could unhook privileged individuals from compulsive health care consumption. This has changed during the last decade: first, because applied science has made an enormous simplification of effective treatments feasible, and the economic crunch will put muscle into the policies that enact this simplification against the interests of big business; second, because a significant minority of practising physicians are now able to understand what popular opinion, supported by medical sociology and economy, has formulated during the last decade.

During the 'sixties, characteristically, even the staunchest critics of medicine obediently assumed the patient role as soon as their clinical tests showed abnormal values. Today, not only in health but also in sickness, a growing minority of people consider the medicalization of life to be, after the atom, the most insidious threat to our and to future generations. They are on the look-out for general practitioners who support their lay convictions, which are based on social science and personal intuition, by providing them with a sound diagnosis of their individual case. They are ready to hear, now and possibly up to the end of their lives, that the consumption of medical care in any form would endanger what they could otherwise do on their own. They want professional assistance to unhook themselves from the system. They seek the momentary support of their physician to resist the temptation of assuming a patient role.

Current trends

This demedicalization has psychological, institutional and cultural aspects, and must not be confused with a list of policies that are now advocated, for other reasons, to effect changes within the medical system. I shall quickly list some of these policy alternatives within medicine. However desirable some of them might be, each could lead to an even more totally medicalized world, a world that enshrines health care at its core.

Firstly, the shift from curative to preventive medicine, while often justified, could also be used as a rationale for more intense medical policing: subtle punishment of disease, rather than its treatment, might lower incidence rates through the medicalization of public morality.

Secondly, the shift from centralized and expensive to decentralized and simpler organization can be used to increase public reliance on constant service.

Thirdly, alternative, oriental or holistic medicine, if recognized, licensed and publicly supported can lead to more, albeit more pluralistic, dependence. Homeo-

Prescribing Information

NEW Zantac

RANITIDINE

Uses

Indications: Zantac Tablets are indicated for the treatment of duodenal ulcer, benign gastric ulcer, post-operative ulcer, reflux oesophagitis and the Zollinger-Ellison syndrome.

Mode of action: Zantac is a highly effective, rapidly acting histamine H₂-antagonist. It inhibits basal and stimulated secretion of gastric acid, reducing both the volume and the acid and pepsin content of the secretion. Zantac has a relatively long duration of action and so a single dose effectively suppresses gastric acid secretion for twelve hours.



Dosage and administration

Adults: The usual dosage is one 150 mg tablet twice daily taken in the morning and before retiring. It is not necessary to time the dose in relation to meals. In most cases of duodenal ulcer, benign gastric ulcer and post-operative ulcer, healing occurs in four weeks. In the small number of patients whose ulcers have not fully healed, healing usually occurs after a further course of treatment. Maintenance treatment at a reduced dosage of one 150 mg tablet at bedtime is recommended for patients who have responded to short-term therapy, particularly those with a history of recurrent ulcer.

In the management of reflux oesophagitis, the recommended course of treatment is one 150 mg tablet twice daily for up to 8 weeks.

In patients with Zollinger-Ellison syndrome, the starting dose is 150 mg three times daily and this may be increased, as necessary, to 900 mg per day.

Children: Experience with Zantac Tablets in children is limited and such use has not been fully evaluated in clinical studies. It has, however, been used successfully in children aged 8-18 years in doses up to 150 mg twice daily without adverse effect.

Contra-indications

There are no known contra-indications to the use of Zantac Tablets.

Precautions

Treatment with a histamine H₂-antagonist may mask symptoms associated with carcinoma of the stomach and may therefore delay diagnosis of the condition.

Accordingly, where gastric ulcer is suspected the possibility of malignancy should be excluded before therapy with Zantac Tablets is instituted.

Ranitidine is excreted via the kidney and so plasma levels of the drug are increased and prolonged in patients with severe renal failure. Accordingly, it is recommended that the therapeutic regimen for Zantac in such patients be 150 mg at night for 4 to 8 weeks. The same dose should be used for maintenance treatment should this be deemed necessary. If an ulcer has not healed after treatment for 4 to 8 weeks and the condition of the patient requires it, the standard dosage regimen of 150 mg twice daily should be instituted, followed, if need be, by maintenance treatment at 150 mg at night.

Although the incidence of adverse reactions in clinical trials of one year's duration and longer has been very low and no serious side effects have been reported with Zantac treatment, care should be taken to carry out periodic examinations of patients on prolonged maintenance treatment with the drug as a safeguard against the occurrence of unforeseeable consequences of drug treatment.

Like other drugs, Zantac should be used during pregnancy and nursing only if strictly necessary. Zantac is secreted in breast milk in lactating mothers but the clinical significance of this has not been fully evaluated.

Side effects

No serious adverse effects have been reported to date in patients treated with Zantac Tablets. There has been no clinically significant interference with endocrine, gonadal or liver function, nor has the drug adversely affected the central nervous system even in elderly patients.

Further information

Drug interactions: Ranitidine does not inhibit the cytochrome P450-linked mixed function oxygenase enzyme system in the liver and therefore does not interfere with the effects of the many drugs which are metabolised by this enzyme system. For example, there is no interaction with warfarin or diazepam.

Pharmacokinetics: Absorption of ranitidine after oral administration is rapid and peak plasma concentrations are usually achieved within two hours of administration. Absorption is not impaired by food or antacids. The elimination half-life of ranitidine is approximately two hours. Ranitidine is excreted via the kidneys mainly as the free drug and in minor amounts as metabolites. Its major metabolite is an N-oxide and there are smaller quantities of S-oxide and desmethyl ranitidine. The 24-hour urinary recovery of free ranitidine and its metabolites is about 40% with orally administered drug.

Use in renal transplants: Zantac has been used without adverse effect in patients with renal transplants.

Product licence number 0004/0279

Basic NHS cost (exclusive of VAT) 60 tablets £27.43.

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paths, acupuncturists, bonesetters, orthomolecular doctors or naturopaths, as well as astrologers, psychoanalysts and other diviners, are able—if they fit the professional model—to create at least as much dependence as a medicalizing general practitioner.

Finally, and most importantly, what now goes under the name of self-help or self-care is a highly ambiguous trend. Self-care is nowadays used as an euphemistic label for many programmes launched by professionals to train their patients in the automedicalization of their lives: watch your blood pressure, feel your breasts, test your urine, budget your calories and service your own body as you maintain your car . . . the parts dealer will profit from it. "Doctor yourself!" is the ultimate slogan in a medicalized world.

Unhooking from the system

If I were a general practitioner, I wonder how I would face these trends. But I am no physician; I have absolutely no experience, and therefore I beg you to consider what I say as an indirect question and not as a piece of advice. Let me take two examples: the woman who expects a child, and a patient who is faced by death in the form of a degenerative disease. Both are today different from patients at the time when my great-grandfather practised. Then, neither would have probably approached a doctor. The first because birth, and the second because death, was none of the doctor's business. Today both persons come to the doctor, because both are trained from youth on to play the multiple patient role. The general practitioner, by triage, can get rid of both. By putting them under his 'police' he can care for them—and then counsel them to accept their dependence. He can let the young woman feel how happy she ought to feel in the strong hands of a wise and experienced doctor, who will see her regularly to tell her that everything is going alright. He can introduce her to a self-help group of women that he, the doctor, has formed out of his patients, and who now assist him to deliver children in the parent's home. Acting in this way the general practitioner is being the most advanced guide into progressive, medicalized self-service, which makes the home into a ward.

However, it seems to me, increasingly, that general practitioners have another chance. They can become one, but just one, of the elements needed by the pregnant woman to unhook herself—and then possibly her child—from dependence on diagnosis and care.

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