

REITH LECTURES 1980: Unmasking Medicine

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Lecture 1: The Rhetoric of Medicine

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Six years ago the American Psychiatric Association took a vote and decided homosexuality was not an illness. So, since 1974 it hasn't been an illness. How extraordinary, you may think, to decide what illness is, by taking a vote. What exactly is going on here?

I've set as my task the unmasking of medicine. It isn't that I think there's something sinister behind the mask. But I do detect a sense of curiosity, of concern, if not disquiet. The practice of medicine has changed. There's a feeling abroad that all may not be well. This feeling grows out of a sense of distance, out of a sense that medicine is in the hands of experts and sets its own path. We can take it or leave it. Heart transplants, the definition of death, the treatment of the dying, the sad fate of Karen Quinlan, the selective treatment of handicapped newly-born babies, the treatment of the mentally ill; there's a long list of issues which are deeply troubling but which seem effectively to be kept under wraps. One of the most successful ways of doing this is by making the issues and problems appear to be medical, technical ones, not really for the rest of us at all. This can be accomplished by the simple device of translating the issue into medical language. I don't mean by this translating it into the technical terms we associate with medicine, but embracing it within the conceptual framework of medicine. The first step on the way to understanding modern medicine, looking behind the mask, is to unravel the rhetoric of medicine.

Let me begin with the word 'illness'. It is, you say, a word you understand. You know what it means and it will take more than one curious example about the activities of the American Psychiatric Association to persuade you otherwise. 'Illness', you insist, is a technical term, a term of scientific exactitude. Whether someone has an illness, is ill, is a matter of objective fact

But homosexuality is as much a part of social life after 1974 as it was before. The objective facts haven't changed. What has changed is how the particular doctors choose to judge it. This suggests the strangely disquieting insight that illness involves not merely the existence of certain facts; it involves a judgment on those facts. And it is doctors who do the judging. A choice exists whether to categorise particular circumstances as amounting to an illness. Power is vested in the doctor, and the power is not insignificant.

It becomes important, then, to discover whether there are boundaries to this word, this concept 'illness'. Can it be applied willy-nilly on the say-so of the doctor, or are there limits to his power? To analyse the word 'illness' is to explore the role of the doctor in modern medicine. It is to discover that medical practice is, above all, a political enterprise, one in which judgments about people are made.

But, you ask, are there not *many* conditions about which we'd all agree that they constitute illnesses? Of course, the answer is yes, there are. Obviously we'd all agree that someone with an inflamed appendix is ill, as is someone who cannot breathe very well, even when resting. Equally, we agree that someone with, say, leprosy or cancer is ill. Why do we all agree? It's obvious, you say. Someone with an inflamed appendix is ill. He's got appendicitis. But this is a circular argument. We have to go more carefully. What we have are certain facts about the physical condition of a person. We all agree that these are illnesses because we accept two propositions. The first is that there is a normal state in which the appendix is not inflamed, and breathing is easy while resting. Secondly, it is appropriate to judge someone who deviates from this norm as ill. Only if we examine both of these will we understand what is involved in the meaning of the word 'illness',

Take the first of the two propositions, that there must be a deviation from the normal state. This seems simple enough. It isn't, of course. For a start, it's only our convention to call such deviations illness. Others in other cultures may view such conditions entirely differently. They may see them as visitations from the gods, as punishments deserved and to be accepted, or as possession by spirits. We cleave to science and the scientific principle of a demonstrable state of normality and a causative agent which brings about an abnormality. Few would object to this convention. Even so, we still have a problem. What is the state we should regard as normal?

A common method of answering this is to have recourse to an analogy drawn from engineering. We think in terms of a machine which has a design, which is the norm and which malfunctions when it does not perform according to the design. Indeed, in common speech we may describe our car as sick, or ill, or on its last legs. And, by and large, this analogy serves us well. But it has its shortcomings. One weakness is that it is crude. We like to think of ourselves as more than machines. We have emotions, moods and feelings which affect profoundly our physical state. A further weakness is that we may not all agree on the design, the blueprint, against which to measure our performance or our state. For example, women have the capacity to bear children. In the old days, it was considered part of the design for women that they bore children. A woman who did not bear children departed from this design. She was to that extent abnormal. She was described as barren, a term with connotations of illness as well as some notion of moral judgment upon her; you'll recall that Julius Caesar urged his wife to touch Antony so as to be cured of her barrenness. To some extent we have changed our view of the design for women. There is probably less inclination now to ascribe to childless women a term suggesting illness or moral judgment.

The point is clear. What is the normal state against which to measure abnormality is a product of social and cultural values and expectations. It is not some static, objectively identifiable fact. As views and values change, so the norm will change. So, if illness has as its first criterion some deviation from the norm, some abnormality, it too will vary and change in its meaning.

Furthermore, I suggested a moment ago that there is a relationship between calling someone ill and making a moral judgment about him. The same abnormality can at different times be illness or evil. When we describe someone as ill, we often say, there's something wrong with him, and the word 'wrong' can also imply lack of

moral worth. Before the days of modern medicine it was common to regard conditions we now regard as illnesses as being attributable to possession by evil spirits. For example, some of those accused of witchcraft by Cotton Mather in 17th-century Massachusetts would probably now be described as epileptics, or as suffering from Huntington's chorea, and seen as ill and certainly not as evil. On the other hand, we fluctuate now in our view as to whether, for example, the alcoholic or the drug-taker is ill or bad.

Running through such examples is the theme of responsibility. As our views of each person's power to exercise dominion over his life change, so will our concept of the borders between illness and evil. For evil is seen as a product of someone's choice and thus something he may be held responsible for. Illness, by contrast, is something which overtakes him, and, once ill, he is absolved from the ordinary responsibilities of everyday life

So illness, a central concept of medicine, is not a matter of objective scientific fact. Instead, it's a term used to describe deviation from a notional norm. So a choice exists whether to call someone ill. The choice depends upon the norm chosen, and this is a matter of social and political judgment. Ordinarily, there will be widespread agreement about what objective facts, what physical states are appropriately described as abnormal. But this does not belie the fact that there is an inherent vagueness in the term 'illness'. And this is only the beginning. Even when it has been decided that the physical conditions warrant the description 'abnormal', there is still the second step. They have to be *judged* to be an illness. An evaluation has to take place.

This should cause us to pause. Who does the evaluating? What are the values involved? Does this mean that the vagueness we previously noticed is compounded? Does this mean that the concept of illness can be manipulated, that it has no clear and certain boundaries? We began with the cosy assumption that 'illness' was a descriptive term, applied to a set of objective facts. It appears now that illness is an indeterminate concept, the product of social, political and moral values which, as we have seen, fluctuate. The implications of this will strike you immediately. If 'illness' is a judgment, the practice of medicine can be understood in terms of power. He who makes the judgment wields the power.

Let me explain the implications of this. The treatment of illness is for doctors. A social institution has grown up defined and managed by doctors, the role of which is to persuade us that our preoccupations must be related to them, and them alone (since they alone have competence). However willing we may be, and however well-intentioned the doctor, it's hard to overstate the power which this vests in the doctor. It is hard to overstate how such a social arrangement may undermine the notion of individual responsibility and, of course, ultimately, individual liberty. Michel Foucault, a contemporary French philosopher, captures the point perfectly when he argues: 'In the modern world all too often there is no clear line between concern for the welfare of others and coercive control of their lives. A new kind of power relationship has arisen in society. Authorities who understand our bodies have gained the right to make and enforce rules about morality.' The nature of the power relationship is seen in terms of confession, now to medical rather than priestly 'authorities'. 'The person who confesses supplies the raw data; the confessor supplies

the meaning,' Foucault asserts. Interpretation, and with it judgment and prescription, become the preserve of authority, since, knowing what we do not know about ourselves, doctors acquire the right to show us how to behave.

Let me take this further. Just because illness is associated with objective facts, it appears that illness is those facts, that illness is a thing. But, as we've seen, illness isn't a thing; it's a judgmental term. Being ill is not a state; it's a status, to be granted or withheld by those who have the power to do so. Status connotes a particular position in society, assumed only after satisfying others that certain conditions have been observed.

Let me explain. Consider Mr Smith. He works on an assembly line. He finds the work dull and tedious. One day, he decides he has had enough and would like just a few days at home. He presents himself to his doctor and asks for a sick note, excusing him from work. Let's analyse this process carefully.

The first stage is the understanding by Smith that he needs authoritative affirmation that he is ill. He may decide he's ill; indeed, it is a feature of modern medicine that, outside emergencies, it is the individual who makes the first decision concerning illness. He stakes a claim to illness. But his decision is not enough. The monopoly power to confirm or deny the presence of illness rests with the doctor. Notice I used the word 'power', not 'skill', since it is more than a technical skill. It is, from what I've already said, a social and political power.

The doctor may say, 'Yes, Mr Smith, you ought to have a few days off', and then add a diagnostic tag such as 'stress' or 'overwork' ('overwork' being clearly an evaluative term). Smith then gets his sick note. Or the doctor may say, 'There's nothing the matter with you, Smith.' His notes may read: 'Another malingerer! What process is involved here? What sort of term is 'malingering'? It involves a judgment that Smith ought to be working and that the doctor is not going to aid him in avoiding this responsibility. Another doctor could just as well decide otherwise.

Besides showing the power the doctor has to manipulate the concept of illness according to his (the doctor's) or the general population's view of what is socially or politically proper, several other points emerge from this example. One is that a major use of the term 'illness' is in a functional sense. Is the person able to function in the role he has? Consider the power this gives the doctor. He may have no idea of what life on an assembly line is like, yet he has the power to decide whether Smith should get back to it or not. It also suggests that the function most clearly involved in the notion of illness is the capacity to work, at least as regards adult males. Health comes to be defined as the ability to work. The doctor reflects and enforces the values of the day: productivity is expected of labour, rest is a reward to be earned.

I choose the example of the sickness certificate for Mr Smith, not because it suits my purpose, but because it is so common and so clear. The inescapable conclusion exists that 'illness' is a spurious scientific term and that the doctor, hi purporting to determine its existence as an objective fact, is engaged in a series of moral, social and political choices which we permit him to make. Of course, many doctors find the position they are in most unsavoury. Frequent protests led the Department of Health to change the form of the sickness note in 1976. But the basic system remained, and

with it the power. The doctor is engaged in a process of socialisation, of ensuring that the prevailing social and political attitudes and values are reinforced and are adhered to by those who, by their behaviour, may be seen as potential deviants.

If you remain unconvinced of the view I am advancing, let's consider Mrs Jones. Married at 19, she is now 35. She stays at home all day, while her husband is at work and their children are at school. She has grown to dread and despise the tedium of her life. She finds her husband boring. She feels trapped. She has ambivalent emotions towards her children. Life, she feels, is passing her by. She finds herself crying most days.

She decides to visit her doctor. She has diagnosed herself as needing help and has chosen the doctor, in the absence of other obvious candidates, as the appropriate provider. She may not think of herself as ill. Indeed, in previous times she may have consulted her priest. Her doctor tells her that she is depressed, something she already knew. The doctor can then confer on her the status of 'ill', if he so chooses, by offering to treat her through the use of his medical expertise. He will provide tranquilisers. More than two-thirds of all prescriptions for such drugs are for women rather than men. It may be no coincidence that women appear 15 times more frequently than men in advertisements for mood-changing drugs.

What does this commerce between the two of them signify? The doctor is prepared to use the flexible term 'illness' to embrace Mrs Jones's condition. By so doing, he endows himself with power over her and satisfies his own and her desire that something be done. A further implication is that he affirms that Mrs Jones is ill, because isn't he treating her? He affirms that her condition is abnormal and that medical intervention is therefore warranted to bring her back to normal. Other women cope. Coping is good. Coping is the norm.

But Mrs Jones's complaint is her dissatisfaction with a social and economic order which robs her of independence and ties her to her home. The doctor can't change the economic and social order, but, with drugs, he can stop her worrying about it. So that's what he does. He returns her to the ranks of unhappy women who no longer feel the pain. By so doing, of course, he prevents the rancour she feels from being expressed in political or social terms. The social and economic status quo is maintained, through the agency of the doctor. He becomes, once again, an agent of the prevailing social system, ensuring that its values persist.

This is not to say that the doctor's role is sinister or conspiratorial. In some large part the doctor acts as a socialiser quite unwittingly. His education has trained him to see illness and to try to ease pain, even if by so doing he merely drives the cork deeper into the bottle, so making uncorking that much more explosive. The doctor is not, of course, wholly innocent, though he may be disquieted. He knows what he's doing. He must resort to such defences as: 'Should I just let her go on being unhappy? That would be too cruel.' It's a hard question to decide which course is the more cruel. Only the other day, a Liverpool doctor, many of whose patients are now unemployed, described on the radio how they came to him for 'a Vali', a Valium tablet. He said he really didn't know what to do. He couldn't give them a job. They were clearly depressed, yet he was reluctant to prescribe drugs for something he saw as a political ill.

Of course, we, the public, have connived at this exercise of power by the doctor, out of ignorance, or trust, or even out of choice. We may well seek sometimes the childlike irresponsibility which the doctor may endow upon us through the diagnosis of illness. There's nothing like being ill occasionally. You are waited on hand and foot, excused from responsibility, indulged and pampered. Victorian ladies avoided all sorts of crises by an attack of vapours, and a headache has been a godsend to many an embattled female. We have opted for what Illich has called the medicalisation of life, the conversion of social and political ills into illnesses, and doctors have not been unwilling to take up the task.

Some of you may say I've given an exaggerated account, that there's a lack of balance here. Well, the two examples I've offered, so far from being unusual, are among the most common encounters between doctors and patients. I'm not saying that we should abandon the use of the word 'illness'. I'm merely urging that we understand what it involves. Since the diagnosis of illness always calls for a judgment, it is right for all of us to consider when it is properly to be applied and who should apply it. We should consider what limits may properly be placed by us on the power of doctors to manipulate the concept. I'm not suggesting we take a vote. But we must make it our business to ensure that the judgments arrived at reflect the considered views of all of us. Each diagnosis is an ethical decision.

So far I have concentrated on the term 'illness'. Let me now consider the concept of health. 'Health', if it is to have any useful meaning, must refer to more than the mere absence of illness. It must have a positive quality. It must refer to all those factors which combine to represent man's aspirations and expectations. But, if expressed in this way, again you see at once that here is no term of nice exactitude. It is, in short, an evaluative term, redolent with moral, spiritual, political and social overtones, and by no means limited to bodily functioning. This is captured in the World Health Organisation's definition of health as 'not the mere absence of disease, but total physical, mental and social well-being'.

This definition, so far from serving as a blueprint for planning and policy, whether for governments or doctors, is customarily held up for ridicule. Among those who ridicule it are doctors. 'What's the use of this sort of airy-fairy thinking?' the argument goes. 'We can't do anything about these things. We've got enough on our hands dealing with the illness about us. We can't make people richer or more comfortable, or whatever "total well-being" means.'

But let's consider this ridicule for a moment. To embrace a notion of health which calls for positive political action and the creation of appropriate economic and social conditions is to concede that health is fundamentally a political term. This most doctors are unwilling to do. They see themselves and want to be seen as scientists, not as the political and social agents I have suggested they often are. And to adopt this approach would be to call for some movement away from investing the great part of our resources in attempting to remedy existing illnesses (a never-ending exercise), towards the principle of preventing, checking or controlling, through social and political action, many of the conditions which give rise to illness.

Very many of the people to whom we are readily prepared to ascribe the status 'ill' find themselves ill because they are poor, grow up in bad housing, eat poor food, work, if at all, at depressing jobs, and generally exist on the margin of survival. The doctor, because of the way medicine has developed, sees himself as powerless in these matters, except as a voting citizen along with everyone else. And his professional vote goes to retaining a notion of health tied to illness, because here he is all-powerful.

The doctor is the entrepreneur of illness. Quite contrary to the view of Sir James Bryce, that medicine is the only profession that labours incessantly to destroy the reason for its own existence, the opposite is true. We have abdicated to doctors the power to define health, with the result that it is predominantly defined in terms of illness and disease. And as long as it is accepted that health is the exclusive preserve of doctors, something only they have competence in, this state of affairs will continue. It is a matter of balance; the power now is with the professional. Only when it is realised that health is far too important to be left entirely to doctors, that it is a matter for all of us, will conditions be created for the necessary redirection of effort and resources. Only then will any real movement towards health be achieved.

Let me end my examination of the rhetoric of medicine by considering the word 'disease'. In doing so, I'll be changing tack somewhat. The notion of disease has less significance in terms of its judgmental quality and the consequent invitation to the exercise of power. It does, however, offer further insight into how the practice of medicine is conceived of. Disease has become a central concept of medicine. It has brought in its wake a number of unfortunate consequences.

Let me explain. If illness involves, at least in part, an abnormal condition, then this abnormality is thought of in terms of disease. Immediately you will notice the danger, at least intellectually, of this approach. We've seen that illness is not a thing, but a judgment. None the less, preoccupation with disease has meant that we have misled ourselves into thinking of illness in essentialist terms, as having a specific essence, of being a thing. Illness becomes the occupation (or possession) of the body by an entity called a disease, caused by some particular agent. You'll notice an earlier religious precursor of this approach, the possession of the body by spirits, a view which still prevails in certain parts of the world. There is a further impeccable pedigree in the case of Pandora, sent as a punishment by Zeus, complete with her box containing, as Robert Graves puts it, 'all the spites that might plague mankind'.

The great spites, or plagues, of the previous centuries, which brought illness and death, were infections, such as cholera, TB or diphtheria. These are memories now, at least in the United Kingdom and other rich industrialised countries. Contrary to popular view, it was not modern medicine which caused them to disappear. Their disappearance was due to three factors: improved housing and sanitation, improved nutrition and improved methods of birth control. By the time that prophylactic measures were available against them, these infections had, in fact, all but disappeared as major threats, at least in terms of bringing widespread death or serious disablement. This is not to overlook the enormous value of vaccination and immunisation in ensuring that pockets of infection do not break out from time to time. There is no doubt that disappearance of the threat from the major infections has been

a magnificent boon. But in terms of the development of modern medicine, it has had two unfortunate consequences.

The first is that the elimination of the major infections has served as the basic evidence—the star witness, if you will—of the triumph of modern medicine over illness. Of course, when examined calmly, the basis of the claim is suspect. Just as infections in the 19th century were not conquered by medicine, so much of today's illness seems curiously resistant to medical attention. None the less, it is thought churlish, if not downright treasonous, to doubt the story or to ask too many questions.

The other unfortunate consequence of the elimination of major infections is that it has provided the intellectual basis for the development and refinement of the notion of disease, as it is now understood. What we now think of as disease is some specific entity, which is caused by an attack on or invasion of a part or parts of the body, or by some malfunction of a part, so as to produce circumstances in which someone complains of feeling ill. The idea has grown up of a one-to-one relationship between disease and its causative agent.

The impact of scientific thinking has provided the ideal climate for this development. The earlier Hippocratic tradition of concern for the whole person in his environment, which had its practical worth in guaranteeing that Greek colonies were established in healthy places, has been ousted by the view that illness is a mechanical failure. Like the machine, the body has functioning parts, each of which, with proper taxonomical skills—skills in classifying—has to be listed and its function explained. And just as the machine will not run for long if a fan belt breaks or a gear cog is stripped, so your body will not function properly if, for example, your kidneys malfunction or are attacked. Humans have been reduced, through the application of impeccable scientific skills, to ambulatory assemblages of parts. Just as medical scientists have identified and tagged the parts of the body, they have persuaded themselves that they can identify and tag those things called diseases. We have witnessed a great flowering in taxonomy whereby genus, species and subspecies of disease have been set down.

Two observations are in order. First, intellectually satisfying as it may be to develop this taxonomy, it is of little use unless it leads to our being able to do anything. Often medical care begins and ends with diagnosis. Second, and far more serious, disease theory has led to an attitude whereby the malady is seen as somehow separate from the sufferer. The disease is what has to be treated, not the person.

But we are more than a set of functioning parts. To regard us as such, as machines, is to overlook the great complexity of each of us. It overlooks the subtle interdependence and interrelationship of the parts which make up the whole. What is wrong with the concept of disease is not that there is no malfunctioning part—there may be. Rather, it's that medicine has come to concentrate on it to the exclusion of all else. Disease theory has induced a sort of medical tunnel vision. What is not seen, as one writer puts it, is the sick person in all his wholeness and variability. Furthermore, it is clearly bad science to conceive of illness in terms of specific diseases caused by specific agents. Not everyone in the last century suffered from TB, though all were doubtless exposed to the bacillus. Nutrition, fatigue and other environmental factors were as important in converting something harmless to some into something deadly to

many. In Ecuador, for example, the World Bank reports that measles has a mortality rate 247 times higher than in the USA.

But this approach to illness, through the identification of specific diseases, is fully in keeping with the application of a sort of primitive scientism to the practice of medicine, as well as reflecting a long intellectual heritage of the notion of possession. Furthermore, it receives constant reinforcement from two principal sources. It is socially and intellectually gratifying for doctors to think of themselves and be thought of as scientists. It connotes working in the realm of knowledge and truth, light years away from the barber and the bleeder of the past. It carries a desirable social cachet. The other source of reinforcement for the notion of disease comes from those who have a vested interest in the continued vitality of the notion of specific disease entities. I think particularly of the pharmaceutical industry.

The relation between the manufacturers of pharmaceutical products and medical education warrants careful attention. In the middle of the 19th century it was discovered that by-products of coal and, later, petroleum refinement could be used to manufacture synthetic dyes, chemicals and drugs. Production of pharmaceutical products grew in conjunction with the development of the petroleum and petrochemical industry. If doctors could be persuaded to reorient medicine towards the notion of pharmacotherapy, then, clearly, here were riches indeed.

The process has been enormously successful, such that modern medicine is almost totally preoccupied with disease identification and disease-specific response; symptom-swatting, as one writer has put it. This is not to say, of course, that all pharmacological intervention is misconceived. That would be stupid in the light of such magnificent developments as the sulphonamides and the antibiotics. It is to say that it has helped to produce or reinforce an attitude to illness which is wrong-headed in several ways.

By concentrating on disease, a form of medicine has developed which, besides being mechanical, is conceived of as a rescue or repair service. But illness, feeling ill and wanting assistance, implies a process far more complicated and subtle than the metaphorical replacement of a fan belt.

By thinking of illness in terms of disease, we have been led to believe that diagnosis leads to cure. This, sadly, is far from accurate. There is little to be gained from labelling if not much can be done once the label has been arrived at. And, of course, the history of modern medicine in general overall terms is that, just as it was not responsible for the elimination of infections in the 19th and early 20th century, so it has had very little impact on the death rate since then. It has had considerable impact on the sickness rate from certain ills, but only limited success in the case of others, particularly those which are the most common among us, such as tooth decay, digestive disorders, skeletal and muscular disabilities, the common cold, heart ailments, coughs and bronchitis, accidents at work and home, stress, pain and unhappiness.

But the myth persists. The whirligig of disease identification goes round and no one seems anxious to stop it or get off. I do not say we should not use the word 'disease'—I merely urge that we understand the dangers implicit in its use.

I have examined three of the central concepts of modern medicine. You have seen some of the implications they hold. They imply judgment and evaluations. If we are to take back power to control our lives, we can and must examine these judgments and evaluations. We must notice how they are applied. We must be sure they conform to our sense of what is right or appropriate. We must become the masters of medicine, not its servants. Let there be no misunderstanding: in the politics of medicine• it is we who must have the power, we who must set the policies. Educating ourselves in the language of medicine is the first step. Our next step is to look at the way modern medicine has developed. I shall suggest next week how in many respects it has taken the wrong road.