REITH LECTURES 1980: Unmasking Medicine

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Lecture 2: The New Magicians

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My view can be stated briefly. Modern medicine has taken the wrong path. An inappropriate form of medicine has been created, in large part by doctors and medical scientists, and eagerly accepted by a willing populace. I will go further. The nature of modern medicine makes it positively deleterious to the health and wellbeing of the population. We have all been willing participants in allowing the creation of a myth, because it seems to serve our interests to believe that illness can be vanquished and death postponed until further notice, while it serves the interests of doctors to see themselves and be seen as, if not miracle workers (and of course they would be the first to deny this), then at least as possible miracle workers.

Science has destroyed our faith in religion. Reason has challenged our trust in magic. What more appropriate result could there be than the appearance of new magicians and priests wrapped in the cloak of science and reason? Please understand that it is we, all of us, who have hitched our wagon to the wrong star, scientific medicine, as our guiding light. The unhappy consequence is that medicine is perceived and pursued in ways which do not best serve the needs of society. We do not put to best use the skills and abilities of those who have become its practitioners.

Let me explain in a series of points what I see as the path taken by modern medicine and how it may be the wrong one. I intend to concentrate on doctors and their attitudes and training. They may represent only seven per cent of the National Health Service workforce, as against, for example, nurses, who represent 43 per cent, but it is they, the doctors, who spend the money and wield the power. Let me make it clear at the outset that, as in all things, what are involved here are questions of emphasis and balance. I know we can all point to many worthy features of medicine. But, on balance, I find modern medicine wanting.

First, as now taught and practised, medicine is avowedly and self-consciously scientific. Far be it from me to stand against the tide of history and suggest there is more to understanding and caring than contained within the four corners of science. But an education which demands high skills in scientific subjects before going to medical school and, once there, involves years of breathing the heady air of one after another field of scientific endeavour, produces what it is intended to produce: a doctor who sees himself as a scientist. It may not produce what is so often needed: someone who can care. I am not suggesting that medical education should not be scientific. Of course it has to be. But room must be found for other disciplines, particularly the humanities. Admittedly, some attempts to meet this point have recently been made in some medical schools. But the late Professor Henry Miller, who was Dean at Newcastle Medical School, was moved to say that the emphasis was still fundamentally scientific, such that what he saw as ‘the crisis in medical education’ still remained unsolved. Moreover, the science now taught only compounds the
problem. It is concerned with reaction, response, to ills which already au the sufferer, instead of emphasising concern for the causes and origins of illness, with a view to preventing them. So, medicine may be called the healing art, but in the practice of that art it is the scientific method which is portrayed as the best, if not the only, way.

My next point is that modern medicine is thought of as dispensing cures. The image created of medicine has increasingly been that of a curative science in which the model of the doctor is that of the engineer-mechanic curing a sick engine. This has reached its high point in what I see as an attitude to death, in which dying has come to be regarded as an illness. Call it an illness and you hold out hope of treatment, control and even cure. Doctor, patient and family become locked in an unholy ‘danse macabre’. Medicine provides another variation on the theme of the pursuit of immortality, with the respirator symbolising some kind of Promethean eternity. But the engineer-mechanic model is an unfortunate one. Quite simply, the problems that beset us now do not seem readily amenable to cure. And I speak now of the generality of ills; those that kill us before our time—cancer, heart disease, respiratory problems and accidents—or those that chip away at our daily pursuit of tranquillity—colds and coughs, aches and pains and simple unhappiness. I do not seek—indeed, it would be quite wrong—to belittle the contribution scientific medicine has made and continues to make, both in curing infections, at least in their short-term effects, and in controlling and soothing numerous otherwise intolerable conditions: in reducing sickness, even if it has had little effect on mortality. But the most common causes of death and the most common debilitating diseases still remain beyond the reach of the doctor. Cures there are not.

The idea of the doctor as an engineer involved in a curative science produces a further consequence which I shall make my third point. It is that doctors are encouraged to adopt the mentality that they are problem-solvers. Problems exist out there in the world which it is their job to solve. What is wrong with that, you ask? Well, it is wrong in several respects. It is a mentality which creates problems. Indeed, the more efficiently doctors look for problems, the more they find and the more problem-solvers we need. It is a mentality which converts modern medical care into crisis care. We wait for a crisis, problem, then we take it to the doctor and expect him to solve it. It is a mentality which fosters the impression that the problem can be solved, an impression all of us readily adopt. Finally, it is a mentality which ignores the notion that problems can be avoided, that waiting for them to arise and then responding to them is a less than adequate way of providing health care.

Another consequence of perceiving medicine as a scientific exercise has meant that it is conceptualised and practised only in terms of specific diseases. Medicine is thus committed to a process of reductionism. The totality of a complex human being, the product of innumerable forces, involving subtle balances and interrelationships, is broken down. He becomes no more than a collection of parts, one or more of which is diseased. Each disease then has its particular name, locus and nature. It is this entity called the disease which then receives attention, not the person. I am not saying we should abandon the notion of disease. It serves a purpose and, anyway, it is too much a part of our vocabulary to exorcise it now. But, if illness is seen only in terms of specific diseases, this induces a form of tunnel vision. Medicine loses sight of the whole person. Miss A. becomes an X-ray projected on a screen, Baby B. becomes a bad case of meningitis, Mr C. becomes the pain in the neck at four o’clock.
My fifth point is that modern medicine teaches that the appropriate response of the doctor to our complaint is to do something, and something aimed at the particular disease entity. If the doctor has been educated to think of himself as a scientist problem-solver and if there is a disease lurking somewhere, then it is his job to seek it out and remedy it. Some form of bodily intervention which is disease-specific is usually sought. Something must be done both to satisfy the expectations of the patient, and the professional pride of the doctor, and it has to be done to the disease, which is portrayed in terms redolent of morality or religion as something bad or wrong which is possessing the body. The process has become one of applying taxonomical skills, skills in classifying so as to identify the disease and then deciding upon the appropriate disease-specific response. Indeed, the process may be even less complicated. One study has shown that the consultant, knowing the limited range of treatments he has available, is typically concerned from the outset with the simple question: which treatment is most suitable? The choice is then validated by appeal to the diagnosis. What is wrong with this mentality of doing something? It is medicine by reflex, wait for the problem and then do something. It is medicine aimed at fixing parts. It is medicine which ignores such questions as how the state of affairs came about, or what the long- or short-term effects of the chosen response will be. It is medicine which particularly ignores the question: should anything be done at all? Such questions will tend to be lost in the display of pseudo-scientific wizardry.

The doctor is not alone in cultivating this mentality. You only have to look at advertisements in the press or on television to see how the notion of disease and disease-specific response is manipulated by drug companies so as to sell their products. Diagrams, effective for all their banality, show target areas with the product winging its way to knock out pain, indigestion, headache, or whatever, and, of course, no one encourages this more than we ourselves. It is so much more satisfying to know that you have arthritis than to be unsure what is the matter. The knowledge operates to put your mind at ease. It could, after all, have been another disease of greater menace on the Richter Scale. But such knowledge says nothing about whether the illness could have been avoided or what impact it will have on your future lifestyle.

The sixth point concerning the inappropriate form medicine has taken is that medicine is increasingly thought of in terms of hospitals. Indeed, the number of hospitals is often cited as a measure of the quality of health care. For example, the Soviet Union was able to claim in the mid-Seventies that, except for Sweden and Norway, it had overtaken all other industrialised nations in the ratio of hospital beds to population size. The implication was that its system of health care had equally advanced, despite the longstanding inadequacy of its primary care services, particularly in the countryside. The nonsense of this approach is obvious. Indeed, apart from units concerned with accidents and, perhaps, obstetrics, the fact that an ever-increasing proportion of our health service budget, now 70 per cent, goes to hospitals could be said to be evidence of the failures of health care and how we perceive it. If ever there was a case of putting the cart before the horse, this is it. If preventive medicine, school health care, community health care and general primary care meant anything, hospitals would be far less needed. Hospitals are the epitome of the problem-solving, disease-oriented, scientific engineer approach. And this idea of hospital-dominated medicine is constantly reinforced in our minds, if only by such things as radio and television programmes, whether they take the form of a soap-opera
or a demonstration of the gee-whiz surgical skills displayed recently in the BBC television programmes *Your Life in Their Hands*. The reasons for thinking of medicine in terms of hospitals are many. Medical students are trained in hospitals. Hospitals are where they learn to see themselves as scientist problem-solvers and curers. Hospitals, particularly teaching hospitals are where all the interesting problems are. Hospital doctors see themselves, and encourage others to see them, as an elite, and those in the teaching hospitals are, of course, a kind of super-elite—leaders of the medical world, shapers of medical education. These teachers become the role models for the future. To borrow Professor Miller’s words, ‘the company of biochemists and geneticists remains more stimulating and more attractive to the bright young medical man than that of social workers and chiropodists’.

It should not come as a surprise that we have exported this same mentality to developing countries. The 1980 World Bank report points to the inappropriate emphasis on curative rather than preventive care, to the excessive construction of hospitals and to the education of doctors which is often not geared to their countries needs, stressing rare diseases and the use of costly equipment while neglecting local health problems. Two-thirds of the health budget of most developing countries goes to medical education and teaching hospitals. The limitations of adopting this approach in developing countries is illustrated by a medical school programme in Colombia for the hospital care of premature infants. Survival rates were achieved which compared well with those in the United States. But 70 per cent of the infants discharged were dead within three months because of infection, malnutrition and general poverty.

With the increasing emphasis on hospitals as the hub of medical care has come another unfortunate feature of modern medicine: that medicine is and should be an enterprise calling for the use of ever more advanced and complex technology. Christiaan Barnard filled the massive football stadium in Rio twice when he talked of his first heart transplant, yet the majority of his audience could not afford the simple medicine to rid themselves of their intestinal worms. And, in his own country, Oxfam was giving out measles vaccine to malnourished children whose lives were at risk from infection. In such a context Schweitzer, in his hospital at Lamberene, is a somewhat ludicrous figure, dissipating his energies, albeit for the most noble of reasons. Pressure on the French government from someone of his stature could well have produced better results for the health of the people of Equatorial Africa than losing himself in a jungle hospital, trying to patch up broken lives.

More and more diagnostic aids, surgical tools and supportive equipment, each more complex than the last, not to mention drugs, the National Health Service bill for which last year amounted to £1,000 million, are pressed on doctors. The trend is as predictable as it is regrettable. If you are trained to think of yourself as a scientist problem-solver, raised in an environment of white coats and machinery where people are constantly being monitored and measured, it is inevitable that you will want the latest machine. Recourse to advanced technology is deemed entirely proper. And those who manufacture such machinery will ensure that the hospital realises that without this particular advanced scanner, or whatever, the care being offered may well be thought of as substandard. The combination of the hospital administration’s nervousness and the doctor’s professional self-image is more than enough to ensure that the machine is categorised as essential, to be obtained as soon as possible. In case you think the picture I am painting is a caricature, consider the National Health
Service’s distinction awards which are given to hospital consultants. The three specialities in which consultants most frequently receive awards are thoracic surgery, neurosurgery and cardiology. Consultants in geriatrics and mental health, two areas where technology has least to offer, although the two areas are blessed with the most patients, receive the fewest awards. So, government, with the aid of the profession, reinforces this technological approach to medicine which I am seeking to illustrate and criticise. The lure of high technology is irresistible to the doctor, serving as both validation and vindication of his training and of his image of himself as really the scientist problem-solver and curer. It is this same mentality which impels the search for so-called wonder drugs. Though doctors may well frown at the term, the pursuit goes on unabashed. Medical research exerts a spell over governments and foundations and thus the public. The spell is that something is just around the corner, a breakthrough is imminent. We are all mesmerised and the premise largely goes unquestioned: whether scientific technological medicine is the right way? Recently, even the much respected medical correspondent of The Times was moved to write of ‘the battle against breast cancer’ under the headline: ‘Is breast cancer next for treatment breakthrough?’ Interferon, an agent produced by the body and alleged to have therapeutic properties, is the latest candidate. It would, of course, be wonderful if it were true, but the record of wonder drugs has not been good since the 1950s.

These are some of the ways in which medicine has taken the wrong path. They are, of course, painted with the broad brush. It is important to realise that I am not denying that every day, up and down the country, wonderful things are being done. Despite this, could the nation’s health be better, or if not better then no worse, at some gain, financial and social, to the citizenry if medicine took a different form?

But the present state of medicine will take some changing. It is cultivated by the medical profession. It flatters the self esteem of the doctor to see himself as the problem-solving scientist spreading health. And the present state of medicine has readily been adopted by a lay public, anxious always for the ideal in health as in other things, and with expectations which may be unwarranted but which are, of course, a product of the claims made by medicine. None the less, although it seems to satisfy the aspirations of the doctor as well as the expectations of the public, in the event no one is satisfied. For a start, the cost of financing medicine in the form it now takes is clearly beyond what we are willing to pay in the form of taxation. We complain if we are asked to forgo anything, but we vote for promises of reduced taxation and reduced public spending. Of course, the dissatisfaction doctors feel, as rising national costs are reflected in their income tax, is tinged with a professional reluctance to countenance any cuts in expenditure on medical care. Indeed, they are voluble, for example, in their demand for the so-called freedom to prescribe, whatever the cost. If drugs were prescribed under their general chemical name rather than under a specific company’s brand name, the NHS would make a considerable saving. Yet doctors resist such an obvious financial control as an unconscionable interference in their rights. No one seems to ask where such rights come from, if not from us. Equally, doctors are the first to urge the acquisition of ever more expensive equipment. Also, albeit with less stridency, they can be heard arguing the need for better conditions for hospital patients. And finally, of course, when it comes to their pay, they have not been slow to keep themselves at or near the head of the professional league, while at the same time insisting on the right to private practice in addition. The bitter comment attributed to Aneurin Bevan that, to win over the consultants to the cause of the
National Health Service, he had ‘choked their mouths with gold’, echoes down the years.

Another reason for dissatisfaction with the state of modern medicine is that we, the public, have been led to expect too much and have been more than willing partners in the process. We have come almost to believe in magic cures and the waving of wands. The reality is a constant disappointment. The promised or expected cures are not there. We are also disappointed for another reason. The simple fact is that for large numbers of people the many and varied services offered by medicine are just not available. And I do not mean here the interventionist, hospital-based medicine I have criticised. I mean the preventive and primary care which large segments of the population do not have ready access to and which, if it were accompanied by other appropriate social measures, would help them pursue and enjoy more healthy lives. I will return to this theme at much greater length next week. Now, I will merely refer you to the 1979 report of the Royal Commission on the Health Service which makes the general point most clearly. ‘In some declining urban areas the National Health Service is failing dismally to provide an adequate primary care system. Since the establishment of the NHS the position of those in social classes four and five appears to have worsened relative to those in social classes one and two.’ Now, more than ever, wealthier means healthier.

A final reason for dissatisfaction is the role the doctor finds himself playing. Reality casts him in a far different role from the one which he has been trained to expect and perform. A tension is produced between the model and the reality, and it has severe repercussions on the morale of doctors. Take the general practitioner. A large part of his daily clientele are people who quite simply are unhappy. In the absence of anyone else to go to and in view of the ready availability of the general practitioner and the extended notion of illness cultivated by doctors, the unhappy person diagnoses himself as ill and then goes to his GP. But the GP is trained to treat those who are ‘really ill’. This is what those years of white coats and science have prepared him for. He thinks his time is being wasted and, more significantly, he feels impotent in the face of the unhappiness being complained of. A 1979 survey showed that a third of all recently qualified GPs felt that they should not have to deal with their patients’ family problems. To do something, the doctor commonly prescribes tranquillisers. Almost a fifth of all prescriptions are for such drugs. Indeed, even the makers of Valium and Librium, Hoffmann-La-Roche, hardly famous for public-spiritedness, were constrained last August to advise doctors in the United States not to prescribe them for the ordinary stresses of life (whatever that may mean) and similar Department of Health guidelines were published last March in the *British Medical Journal*.

So, the GP finds himself playing the part of socialising agent, ensuring that, whether it be unhappiness or the stress of work, they are kept in check and whatever pain there is, is not felt, even if this means that the social and economic conditions which give rise to the unhappiness remain unaddressed. Alternatively, the GP finds himself faced by those beset by today’s common ills. He is in danger of becoming the victim of his own hyperbole, in that he is asked to work wonders when there are none to work. The damage has been done. There are only symptoms to ease, parts to patch. The frustration is inevitable.
Then consider the doctors who work in hospital. If accident units, and perhaps obstetrics, are put aside, hospitals are now largely engaged in two tasks, neither of which remotely conforms to the image of modern medicine represented by the teaching hospital. One task is that of serving as dumping-grounds for the old and so-called mentally ill. The hospital is little more than a hotel or hostel. The frustration of the doctor trained to see himself not as a carer but as a solver is obvious and it can only increase as the elderly come to form an even greater proportion of the population. Indeed, quite whether doctors, as trained at present, have a role to play at all in such hospitals, or whether others could not do the job just as well, is a question which presses for an answer.

The other task doctors in hospitals are performing is that of calling upon more and more complex and expensive technology to respond to situations in which, when one looks at the general overall picture, there is usually little that can be done. To use the metaphor of the mechanic, the tyre can be patched, but even so it is permanently weak. I know well that there are some who will say, ‘It’s all very well talking in general terms, but I’ve got Mr A., who is clamouring for help, or Miss B., whom I may be able to help. Then there’s old Mrs C.’s hip operation, and Mr D.’s hernia to fix. I cannot tell them to think of the generality of care, I have a duty to them.’ I concede much of this, but let me make two points. I am not advocating we burn down our hospitals tomorrow. Of course we need our marvellous accident units, our general medicine and surgery, whether it be for hips or hernias, haemorrhoids or Hodgkin’s disease. But, even here, I wonder how much more rewarding and beneficial it would be to prevent, for instance, the degeneration of the hip or to have other preventive measures; for example, a production system which does not give productivity bonuses or does not use piece-rates in industries in which these are known to be associated with an increase in work accidents. How much more rewarding these measures would be than to have units waiting to pick up the pieces and work wonders in sewing the parts together so that the seams are barely visible. If these preventive strategies were pursued, greater attention could then be paid to the marvellous developments; for example, in aiding those with ailing sight or hearing. My second point is that, put baldly, certain services should not be offered until matters of greater priority are dealt with. There are perfectly respectable ethical theories which, in the context of harsh choices, such as those we face now (and always will as regards resources), allow for conduct which will benefit the larger or more worthy number, even if this inevitably means the others may suffer. One example was the decision in the Second World War in North Africa that only those who, on recovery, would be able to fight again should receive scarce penicillin. Another is the decision now being taken in Uganda to feed only those starving children who may recover, leaving the rest to die. Our situation is not so desperate, but the same principle must apply. Indeed, such decisions are made every day in the National Health Service when resources come to be allocated. As one writer, a doctor and theologian, argued recently, ‘Only when we are prepared to let some people die will we be free to make more humane decisions in the distribution of resources. Our fear of death leads us to use death as the final, incontrovertible argument’. We are prepared to ignore much human misery for the spectacle of saving a few lives. Not so long ago, a senior civil servant remarked that consultants opposed to shifts of resources from the well-endowed areas of medicine to the Cinderella areas of geriatrics and mental illness have not been averse to using ‘shroud-waving tactics’. 
Well, after these rather harsh words about the wrong emphasis adopted by modern medicine, the wrong path it has taken, I shall consider next time how the emphasis should be shifted; what a better path for the future may be.