The social distortion of medical practice

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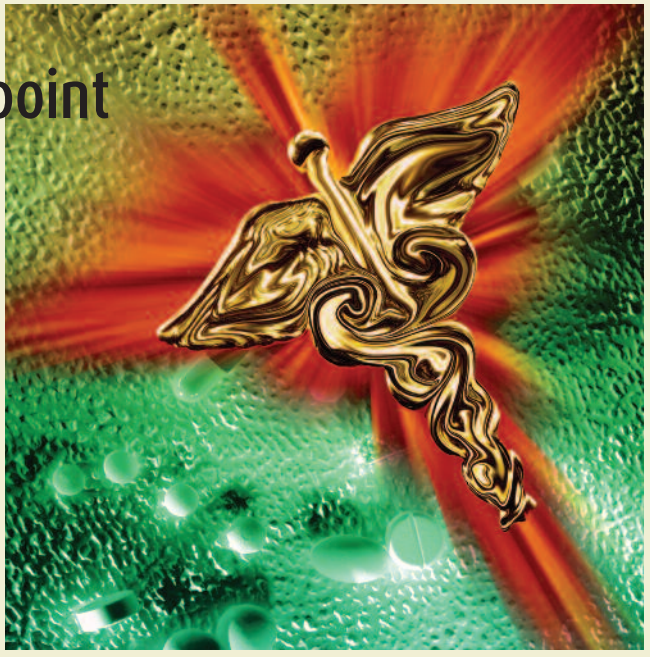
While health is a major political issue and health professionals are unavoidably involved to some extent in financing and resource allocation, it is also neither reasonable nor possible to divorce the practice of medicine from the societal culture in which it is practised.



Doctors and their organisations worldwide have been jolted by the collapse of some insurance and indemnity institutions, increasing criticism of hallowed ideologies and a reduction in societal status. Among some, there are calls for 'medical professionalism'.[1-3] Much of the pageant of scientific, diagnostic and therapeutic progress is admirable, but some behaviours developed to protect status and the accelerating development of a health–disease industry could be leading to professional self-destruction.[4-8]

The sociocultural and political influence of medicine on citizens individually and collectively has never been stronger. Conversely, and despite the socialisation of medicine, the criticism of conventional health practitioners and their practice by society has never been more vociferous or sustained. Health is a major political issue, especially at a local level. This is well illustrated by the usual community response to a threatened regional hospital closure.

In Australasia, as in some sections of healthcare in the USA, health professionals believe and defend the concept that the primacy, privacy and consequent advocacy of the doctor–patient interaction excuses a practitioner from involvement in the politics of financing and resource allocation (rationing). Those who subscribe to this narrow viewpoint are disenfranchising themselves from crucial decision making forums that will determine future medical practice.

The criticisms of medicine

Medicine in Australia and New Zealand has been and is subject to considerable, and often appropriate, criticism. This criticism centres on the conduct and safety of medicine and not about the 'medicalisation' of society *per se*.[9] To some degree the criticism misses the big picture.

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We are of the opinion that it is neither reasonable nor possible to divorce the practice of medicine from the societal culture in which that medicine is practised. At one level, factors such as access to compensation not only influence the morbidity of established conditions but also the very existence of some, such as the whiplash syndrome.[10-12] At another level, a triumph of medical science and the health–disease industry – the eradication of smallpox – is threatened by political and military influences on wider society.

The medical market and protectionism

A primary concern of the medical profession has been orthodox medical patch creation and protection, and the allied cronyism. Colleges and Societies have striven to raise and protect standards while adopting protectionist policies (for example, fees and entry criteria). The primary drive to specialisation in medicine over the last 150 years has been to create a market niche for an increasing number of practitioners. In North America, for example, there are now three times as many specialists as there are general practitioners.

To a large degree, the medical market has been increased by the 'medicalisation' of normal life events and by the 'selling' of novel therapies.[13] An example is given in the box on page 76.[14-20] The financial costs to society are often profound. This is not to say that medicalisation of normality is always bad. Indeed, there have been some significant advantages to society in the medicalisation of being born and dying. At the other end of the spectrum, the determination of responses to stress as 'stress disorders' has almost certainly created disability and disease.[6,9,21] There is certainly considerable evidence of the phenomenon of therapies in search of diseases. For example, the role of modern radiology in surgical decision making for patients with back pain, whereby radiological images were used as a basis for the decision to operate long before the equivalent radiological appearance of people without pain was determined.[22]

Resistance to auditing

The medical profession, as is true for any powerful guild, resists any form of audit and especially external audit. There is little real understanding among medical practitioners of what an audit should comprise. For example, discussions of the basis of an audit for laparoscopic surgery for cholecystectomy would not primarily address rates of wound infection or dehiscence, as suggested by most of the surgeons we talked to. Instead, the audit would be more interested in the relative frequency at which patients presented to their general practitioner complaining of abdominal pain before and after the surgical intervention.

Assessing the facts

The gold standard of the randomised double-blind crossover study has been promoted by the pharmaceutical industry and leading medical journals because it is appropriate for drug trials. However, the mode of data presentation, plus the perspective of the presenter, can significantly affect the interpretation and practical application of the results. For instance, if the mortality rates in control and treatment groups are 16 and 8%, respectively, an 8% absolute reduction in mortality can be reported as a 50% relative reduction in mortality.

Most nondrug trials cannot accommodate the rigid standards of blinded crossover studies, such that potentially beneficial therapies may be discounted or, in the case of many surgical procedures, introduced without any real evaluation. This feature of 'therapeutic progress' is well described by Jonathan Kaplan in his book, *The dressing station: a surgeon's odyssey*.[25] Kaplan, working on a new cardiovascular device at a prestigious US medical centre, had his research terminated because a rival sponsor (corporation) purchased the rights to the protocol and terminated the project.

Nonrealisation of benefits from discoveries

While the scientific and current period of medicine has created profound public expectations, a high proportion of 'major discoveries' have not translated into any real early or even actual patient benefit.[6,8,26] Any enthusiasm about the medical implications of the description of the human genome probably needs to be tempered in this context.

The increasing interest in alternative medicine demonstrates that society's needs, regardless of their merit, are not being met.

Incomplete and nonscientific dogma

Other difficulties arise from the abandonment or nonunderstanding of scientific principles by the 'scientifically based' medical orthodoxy. True science operates by using advances in knowledge to test, and frequently disprove, current dogma. While it is necessary and valid to challenge practitioners of 'traditional' and 'nonorthodox' therapies to prove the efficacy of their promotions, allopathic medicine in turn needs to educate itself and its public regarding the need for continual modification of its own wares.

Uncertain cost benefits of advances

There is a current preoccupation with promotions for treatment of the hypothetical but nonexistent average family. This must be tempered with public education about how gains from 'medical miracles' become increasingly marginal at increasing communal cost.

An epidemic of limb pain in telephonists

New Zealand occupational physicians saw an epidemic of upper limb pain in telephonists in 1998 and 1999; almost all were women and most were diagnosed as having an occupational` overuse syndrome, formerly called repetitive strain injury (RSI).[14] These women had undergone an average of more than 100 physiotherapy treatments and four or five surgical procedures.

A syndrome exists only when a group of people, by way of meeting selection criteria, is shown to have a common set of symptoms or clinical or investigation findings. The point of defining a syndrome cohort is to determine if there is an underlying cause or treatment, or both. The term occupational overuse syndrome implies that aetiology is understood at the outset. This is not so.[15] Moreover, clinical audits of these telephonists showed that only about 10% of the subject group had a clear history of a work injury, according to strict criteria.[16,17]

We have written previously about the importance of being certain a problem is due to work before describing it as such, and have highlighted potentially undesirable effects on both employers and employees of an assumed work relationship.[18-20] We believe a majority of these women were categorised as having occupational overuse syndrome because the GPs were uncertain of the diagnosis and accepted their patients' offered explanations and even treatment plans. There was an accessible and large health industry that could 'treat' the condition. Moreover, GPs in New Zealand often select a statutorily (Accident Compensation Corporation) compatible diagnosis to bypass the public health system and achieve higher levels of financial support for their patients.[18-20]

Once the label occupational overuse syndrome had been applied, ergonomic issues were addressed almost exclusively instead of the real underlying problems, which were largely to do with poor office management such as lack of tenure, privacy and work autonomy. Patient management was almost without exception determined by the received diagnosis. This explains the extraordinarily large number of physiotherapy treatments and surgical procedures and the inappropriate management overall.[20] The outstanding feature of this group of women was their very poor clinical outcome.

Lack of precision and certainty

The uncertainty and imprecision of clinical practice are viewed by some health professionals and members of the public as counterintuitive to their perceptions of modern allopathic medicine.[27] Imprecision lurks behind the pressure to categorise 'precisely' and there is an inherent uncertainty in clinical decision making.

Inducements

Self-promotion by medical scientists and members of various disciplines is an increasing feature of the scramble for scarce resources. Many health professionals are themselves cynical but retain powerful inducements to support the health–disease industry generally. Pragmatism of an insidiously destructive form for sound ethical behaviour creeps into doctor–patient–societal relationships, and the quality of science suffers inevitably.[26,28-30] An example of this is given in the box on this page.[31-35] The scientific quality may not be ameliorated by an insistence on basing clinical practice on publications in peer reviewed journals – a recent Cochrane review has shown that such a practice does not appear to ensure biomedical research quality.[36]

Violating human rights

Certain medical practitioners in the last century were partially or entirely responsible for some of the worst violations of human rights. Examples include some programs administered by medical professionals under German National Socialism and at the Soviet Gulags, and experiments conducted on people in China on behalf of the Japanese Empire.[6,37] These shameful episodes are counterbalanced by the heroic stance against political tyranny of some medical practitioners such as the late Frances Ames in South Africa.[38]

Certification – a public function

In the 1980s, the aviation industry in the United Kingdom and elsewhere recognised the hazards that were inherent in management–employee interactions and the 'lethal combination of human error and a weak organisational structure'.[31]

In 2000, we undertook a random audit of the New Zealand Civil Aviation Authority pilot medical files.[32] European, Australian and North American experts agreed with our findings and conclusion. More than half of the files were flawed – most flaws were trivial, but some errors certified pilots as fit to fly when they should not have been so licensed.

We believe that this unacceptably poor practice did not have its roots in doctor dishonesty or incompetence, but rather in system design with consequent 'funder capture' – the pilots funded the medical assessment system, and it quickly became responsive to their needs. The system contained no systematically established external audit or rigid, mandatory confidential reporting to ensure safety through identification of problems involving individual pilots. Not surprisingly, there was an observable drift in practice, sustained by collegial reinforcement. Some doctors lost perspective of their primary obligation to the government and people of New Zealand, and saw their primary role as that of pilot advocacy.[33] Concurrently, the New Zealand Medical Council's draft guidelines on 'certification' stated that a doctor's first responsibility was 'to the patient'.[34] This is wrong in law. Rather, in the context of certification, and particularly for a third party, such as a Department of Labour or an insurance company, the legal responsibility of a medical practitioner is to that third party for whom they are acting as a commissioned agent.[35]

Conclusion

We believe that there is still a significant resistance to any form of external audit, let alone random audit, in most medical practice. In the two case studies, primary forces were the maintenance of a market and the collegial and ineffective nature of any audit. Both studies illustrate client advocacy and the phenomenon of funder capture of a medical practitioner group. They strongly support the hypothesis that social forces are potent distorting influences on medical practice.

Both short term and long term corrective strategies are recommended. In the short term, there is a need for international strategies that are designed to achieve diagnostic integrity and which are accompanied by consistent or random external audit, or both. In the longer term, there is an urgent need for revised legislation and for clinical input to any future relevant legislation. In particular, it is important that there be a resolution of the inequities that exist for access to health care and related support for different races and sections of society. Similarly, this access should be determined by the nature and not by the cause of a person's disability.

Finally, we believe there is a need for a debate about the role of medicine in our society, especially the medicalisation of normality. MT

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A list of references is available on request to the editorial office.

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