

A medical student's response

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Editor's note

The author, a clinical medical student and this year's president of the London Medical Group, argues that Kennedy is right in claiming that medicine does not serve the best interests of the majority of people but wrong to blame the medical profession. The culprits are 'the managers and controllers of "Capital" . . . Government, multinationals, banks, economic think-tanks, the media, etc.' Like Kennedy he believes that medical students are 'inadequately equipped to handle or even distinguish ethical problems' and argues that moral philosophy should be included in medical education.

As a clinical student at a London teaching hospital, my immediate reactions to the Reith Lectures were that although little of Kennedy's analysis of medicine was new, his involvement in the wider debate about ways of improving health was to be welcomed.

Within the philosophy of science lie at least three different schools of thought:

- 1) That science is neutral and that only its application is political.
- 2) That science is a social process, supported by and conducted on behalf of the public, whom it ultimately serves.
- 3) That science is a social product, that is, scientific research reflects and helps perpetuate the interests and ideologies of the socio-economic system.

The first two positions I reject: the first on the ground that there is not such a thing as value-free science; and the second because science is practised by professional élites whose judgments are based on considerations which are often obscure to the public and subject to little public regulation and accountability. If, as I am certain is the case, Kennedy accepts the third proposition, that science is a social product, then any criticism of medicine must bear this in mind. Medicine does not exist in isolation from broader ideologies and social structures. Medicine is as it is, not because of what doctors say and do, but primarily because it has been shaped by a particular socio-economic and political system. Admittedly, doctors' attitudes often unwittingly tend to reflect and reinforce the dominant values of this system in their work. The impression Kennedy left was that whether they know it or not, doctors alone stand between the

present disease-oriented service and the desired health-oriented service. I find it difficult to believe that the nature of medicine can be changed (by demystification, consumer power or whatever) in spite of the economic forces of society within which medicine operates.

Today most of the major preventable causes of disease, accidents and premature deaths have their roots in a hostile environment. This environment in turn is largely moulded by economic goals, policies and practices. The underlying goal is growth – that is the maximising of marketed production and consumption – a goal which some seem to think is the same thing as meeting human needs! Thus, for example, in the name of 'progress' and international competition (produce and sell more, and more quickly, to keep up with the others), nearly two million pounds a week is spent promoting tobacco consumption; children experiencing an epidemic of dental caries are encouraged to suck even more sugary products; and adults are seduced into drinking more alcohol and buying faster cars.

Concepts like prevention and public health, decentralisation and paramedicalisation which Kennedy stressed repeatedly, are totally at odds with economic goals whose productive efficiency demands minimal control of pollution and work hazards, requires economies of scale (*eg* the concentration of capital in massive hospitals) and encourages centralised hierarchical decision-making (which fosters élitism).

As a consequence of this obsession with growth, which reflects supremacy of the profit motive, there has developed a nationalised (*not* socialised) treatment and care service, the function of which is largely to patch up and palliate the effects of the antisocial environment (the repair and engineering approach to disease which Kennedy criticised).

Kennedy is right in suggesting that medicine does not serve the best interests of the majority of people, but this is no accident since the needs in society which tend to be satisfied are generally those of its more powerful economic and political groups. The NHS serves a vital function in ameliorating the worst excess of indiscriminate economic growth, in addition to providing a 'patch-up-and-send-back-to-work' service. It is this function which underpins social and welfare policy, and shapes the nature and orientation of medicine. The NHS is also a source of profit; for example, Kennedy briefly

referred to the influence the pharmaceutical industry has had in shaping the specific drug-disease model, and to the influence manufacturers of sophisticated machinery have had in creating a high-technology interventionist philosophy.

Kennedy lays the blame for the creation of an inappropriate form of medicine largely on the shoulders of the medical profession. The effect of that is to camouflage the real and more telling relationship between economics and health, and to divert attention away from the prime determinants of ill health in a society where undirected economic growth takes precedence over health-promoting programmes.

I agree with Kennedy that doctors wield power by virtue of their massive spending capacity, but their power is nevertheless limited; the real power lies with the economic forces responsible for manipulating the prevailing scientific ideology (*ie* high technology, disease and drug-oriented medicine, large hospitals etc) to their own ends. Kennedy in criticising the medical profession is criticising the custodians of inappropriate medicine, but not its creators (who are the managers and controllers of 'Capital').

General health, Kennedy pointed out, has little to do with medicine; rather it is the product of political and economic decisions. My impression is that Kennedy feels that health services should be capable of readdressing these political and economic decisions, but that our NHS has somehow failed us! Surely, once we have recognised that health status is linked with such things as housing, nutrition, occupation, transport (*ie* accidents), advertising and so on, we must forego the notion that health status is mainly dependent on the curative work of health professionals and health services, and direct our attention towards those who have the real power – the Government, the multinationals, the banks, economic think-tanks, the media etc – to effect changes necessary to promote health.

Treatment and care services will always be necessary and I do not nurture a fantasy of perfect human health or ever-increasing longevity, but it is only within the small area of health that medicine can influence that we need the sensible balance between primary and tertiary care which Kennedy was at pains to emphasise.

As a health student experiencing the present education system, I fully endorse Kennedy's view that the medical curriculum leaves students inadequately equipped to handle or even distinguish ethical problems.

One is constantly reminded by clinicians that what is required in medicine is a quick decision and an immediate therapeutic response. But the areas of medicine in which this requirement is paramount are never clearly defined and the 'medicine by reflex' approach is often carried over into areas calling for more detailed analysis and debate.

For a student to go through two rigorous years of pre-clinical training only to discover that the hours spent in laboratories have constituted an inadequate preparation for the actual practice of medicine is not only subjectively disturbing, it is objectively indefensible – and more importantly it is avoidable. The need for ethical and humanitarian education in medical schools is now more necessary than ever, if we are to achieve the celebrated ideal of the 'humanist physician'. The reasons for this are twofold.

First, the rapid development of technology has both raised new ethical problems and disrupted established ethical codes and practices. Consider for example the issue of euthanasia. What gives deliberations about euthanasia a new urgency is our increased capacity to sustain life beyond reasonable hope of recovery. How one ought to die and the extent to which one ought to be able to influence or determine the manner and mode of one's death are old questions. What is new is the capacity of medical technology to intervene in what were previously dramas that played themselves out naturally.

Genuinely new moral problems arising from recent developments are those relating to the ability to separate sexual and reproductive activity; new techniques for obtaining and handling information; increased understanding of human physiology (leading for example to more complex definitions of death); development of psychopharmaceutical methods of control; and the ability to conduct research or intervene therapeutically in ways that involve manipulations of human development (genetic engineering). All require study.

My second reason for suggesting that it is more important now than ever before that moral philosophy be included in medical education is that the physician's role is in need of re-evaluation and redefinition. The doctor has travelled unwittingly from the safe role of comforter to the sick, to the uneasy position of social engineer and political advocate. Kennedy analysed this evolution, by reviewing definitions of 'normality', the power of the 'medical model' and the expansion of individual treatment into social engineering. Even if the power of decision is shared, it seems that doctors will always be an inevitable and important co-participant. It is central to their role and they must be trained for it.

Guidelines and precedents for teaching medical ethics do exist. In 1967 the General Medical Council's 'Recommendations as to basic medical education' suggested topics not then taught in the undergraduate course should be included in the curriculum – medical ethics was one of nine such topics. There are encouraging signs of formal ethics teaching at a few British medical schools (notably Southampton, Nottingham and Edinburgh); sadly although predictably, these do not include the London medical schools.

However, the traditional taxonomy of medical ethics focusing on medical etiquette, codes of conduct and problems of the doctor-patient relationship (which have a non-accidental compatibility with the individualism of capitalist society), must be reappraised and superseded by a more genuinely philosophical approach. Such critical and challenging concepts as autonomy, coercion, normality, rights, dependency, justice, responsibility, needs and wants, personhood, etc., should be openly and freely discussed. Another virtue of such an approach would be that it would enable philosophers, doctors and students to pool their expertise and apply it to both old and new issues and problems. The opening up of discussion on what is jealously guarded medical territory might directly help doctors with difficult decisions to make,

by promoting an increased ethical awareness, with more emphasis on cognition and thinking, and less on intuition and emotion.

Kennedy's important contribution to the health debate was to highlight and publicise the erroneous but common reductionist assumption that patient behaviour is a consequence of pathology. What is needed, argued Kennedy, is a fundamental realignment of our priorities to accommodate the fact that pathology is all too often a consequence of the social environment. But Kennedy stopped short of explaining that such 'assumptions' are themselves products of powerful economic and social interests and that any shift towards saner health policies presupposes major modification in the wider economic environment and changes in socio-political goals and policies.