

INTRODUCTION

Chapter Summary

This chapter describes:

- » some indicators of medicine's power as an institution;
- » the relationship of trust between an individual doctor and a patient as central to medicine's influential role;
- » how critics have suggested that medicine's influence is overbearing and that trust in the beneficence of medicine has been eroded by recent scandals;
- » how medicine's obligations to promoting equitable levels of health between social groups and the need to promote equity in its own ranks are linked to similar prejudices;
- » how inequalities within medicine reflect those in the wider world.

Useful terms for this chapter

iatrogenesis: an illness or injury introduced as a result of medical intervention that was intended to be therapeutic

medical sociology: the study of the structural and cultural features of medicine as an institution, a profession and a discipline: scholarship in this area is also termed the 'sociology of health and illness' to underline that understandings of health and illness in society are not confined to medicine, but encompass a broader field of enquiry

medicalization: a process whereby conditions formerly seen as non-medical come to be defined and treated as medical problems

paternalistic: acting on behalf of other people and claiming to promote their best interests, without seeking their views or asking their permission

racism: discriminatory attitudes or practice based on prejudices about ethnic or cultural groups

sexism: discriminatory attitudes or practice based on prejudices about men and women

sociology: the study of human society and social relations, initially associated with the social problems of industrializing nations

MEDICINE'S POWER, INFLUENCE AND REPUTATION

This book is about how society understands and responds to those who get ill and, in particular, the role that medicine plays in this relationship. Maintaining health, preventing illness, treating disease and coping with death all occur in daily life, in people's homes, with their friends, neighbours, work-mates, partners and families. While the main source of support for the sick is usually networks of kith and kin, societies of all types have healers who specialize in attending and assisting the sick. Healers use their experience of the expected course of an illness to advise an invalid's supporters on caring for him or her.

A striking feature of contemporary wealthy nations is that healing as an occupation has developed from a small-scale enterprise to become an enormous industry that provides health services through public and private funding. The organization of modern health services is complex, as is the pattern of interaction with other statutory services, such as education and welfare and non-statutory services including religious organizations (churches, missions, temples, and mosques), charities (Scope, The Terence Higgins Trust) and voluntary organizations such as self-help groups and hospital visitors. Multi-national commercial interests form part of the healthcare industry, by manufacturing and supplying products and services to the National Health Service (NHS) and other health and social care organizations, including medical machines, software, pharmaceuticals, orthotic and prosthetic devices, private health insurance, institutional care for the elderly, and alternative therapies. At the heart of this network of interconnections is medicine which plays a central role in managing not only medical services, but also nursing, midwifery, physiotherapy, audiology and other allied professions, in regulating the limits of alternative or complementary therapies, in shaping the direction of research and policy and exercising influence in neighbouring disciplines such as psychology, genetics and public health.

Medicine's role as key player in the broad business of healthcare means it is regularly in negotiation, in contention and sometimes in conflict with other interest groups. Groups with whom medicine negotiates over whose interests are being best served include those citizens whose taxes fund healthcare, patients who use the service, politicians who formulate health policy, healthcare professionals, including management and other clinicians, and regulatory and advisory bodies such as the Human Fertilization and Embryo Authority.

Medicine's official bodies – the British Medical Association (BMA) and the General Medical Council (GMC) – relate to other public bodies including national and local government health officials and associations of other health professionals, such as nursing and dentistry, through representation on committees and the membership of official working parties.

BOX 1

The General Medical Council

The purpose of the General Medical Council (GMC) is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

The law gives us four main functions under the Medical Act:

- keeping up-to-date registers of qualified doctors;
- fostering good medical practice;
- promoting high standards of medical education;
- dealing firmly and fairly with doctors whose fitness to practise is in doubt. (Available at: <http://www.gmc-uk.org/>)

Collectively, doctors' views are represented to the general public through reports and press releases on a range of matters, from drugs licensing to immunization uptake and are also discussed through journals of research and practice (*The British Medical Journal*, *The Lancet*) and other professional journals (*Hospital Doctor*, *Doctor*, *Pulse*, *Health Services Journal*). Medical issues are not confined to formal policy, service provision and academic circles, since their salience and human interest are covered in television, radio programming and in fictionalized form in medical soap operas and dramas as well as in newspaper, magazine and internet health pages.

BOX 2

The British Medical Association

The British Medical Association is the doctors' professional organisation established to look after the professional and personal needs of our members. The BMA represents doctors in all branches of medicine all over the UK ... We are a voluntary association with over two-thirds of practising UK doctors in membership and an independent trade union dedicated to protecting individual members and the collective interests of doctors ... We are the voice for

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doctors and medical students – in constant contact with ministers, government departments, members of the UK, Scottish, Welsh and Northern Ireland administrations and many other influential bodies. We are committed to keeping members in touch with the profession's collective views and policies and to being at the forefront of healthcare development ... We promote the medical and allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality healthcare. (Available at: <http://www.bina.org.uk/>)

Medicine uses all available communication channels and lobbying opportunities and as a professional group is influential, well connected and vociferous. But despite the large scale, wide range and great complexity of medicine's interests, its view of its own worth is based on the nature of the relationship between doctor and patient. The idea that doctors are regarded as professionals who, when consulted, can be trusted to act in the best interests of their patients is crucial to underpinning the influential role that medicine enjoys. The power that medicine has wielded in determining the development of publicly funded health services has been offset by the sense that altruism and a desire to help others are doctors' prime motivations. The vocational nature of medicine is well established in the public's view of medicine so that seeking medical training and employment is seen as a good thing for society at large, as well as for the individual who will be employed as a doctor. The material reward that individual doctors receive has generally been viewed as a side issue and not as a measure of medicine's worth to society. Relative to other professions with a similar length of training, medicine is a well-remunerated occupation, with good conditions of employment, which have been achieved through skilful negotiation. The state has been prepared to underwrite the costs of employing doctors because medicine has been seen as an essential service, important to national wellbeing, and doctors are seen as trustworthy professionals.

TRUST IN MEDICINE

In terms of understanding the dilemmas that face medicine today, the paradox of a profession that justifies its international political and commercial influence on the basis of the trustworthiness of its one-to-one interactions with clients is important. Medicine's claim that doctors are professionals with a vocational calling whose extensive training and distinctive knowledge are harnessed to serving the public good is challenged by evidence of less

noble motivations in some quarters. Medicine's emphasis on the beneficent relationship with clients has been subject to criticism, not least from research that has demonstrated the ways that the interests of the institution of medicine often outweigh those of patients in the organization of healthcare (see Chapter 8). For example, the independent inquiry into paediatric cardiologists' practice in Bristol found that professional rather than patient interests had been paramount. Such evidence that professional ethics do not, in fact, guarantee disinterested, impartial behaviour has received media attention in Britain and it has become abundantly clear that doctors, like any group in society, demonstrate all of our inherent human failings, including, sadly, the ability to murder. The withdrawal of respect for and trust in professionals is not confined to doctors however, with politicians, social workers and the clergy suffering a similar fate. Yet this is particularly worrisome for medicine which depends on intimate access to people's bodies, and to details of their daily lives, in order to diagnose and practise. Medical scandals are assessed by the medical press in terms of the impact on the trust between doctor and patient. An editorial in the *British Medical Journal* after Harold Shipman's conviction for murdering fifteen of his patients stated

Serial killers in healthcare like Shipman ... are particularly shocking because they damage the trust that exists between clinicians and their patients. (O'Neill, 2000)

The maintenance of trust between doctor and patient is of prime concern to today's medical profession, but it is not a new preoccupation for medicine. Only one hundred years ago physicians were part of a small-scale trade, lacking any potent means of altering the course of disease and competing with other types of healers for clients (see Chapter 1). Relying on the fees paid by patients meant that a doctor's sympathetic and authoritative bedside manner was crucial to attracting and retaining clients. Medicine has since developed to be part of a vast 'medical-industrial complex' (Illich, 1976) which has confidence in its ability to defeat disease. During the period when faith in the scientific approach accompanied a massive expansion in research activity, the issue of patient respect may have been less pressing than scientifically informed advances.

However, even without such evidence of malpractice attracting news headlines, medicine's authority and social standing would inevitably be subject to criticism. One consistent criticism has been that medicine's success and power have led it to ignore the interests of other players involved in the delivery of healthcare. Patients' groups complain that the disease rather than the sick person is the focus of medical interest and that the patient's occupational, financial and caring roles are ignored when they should be taken into consideration when planning treatment for optimal recovery. Nurses protest about their relegation to the role of handmaiden to the medical project, when they should be respected as clinicians with specific skills and responsibilities.

Alternative therapists dispute their exclusion from the legally-sanctioned, state-funded monopoly on healing that medicine enjoys and midwives point to their eviction as the expert occupational group dealing with birth. Critics describe how medicine's methods can damage individual and collective health in the name of effecting a cure (referred to as iatrogenesis). Others from within and beyond the medical profession also suggest that medicine's influence is too pervasive and its perspectives have been overbearing in matters of mental illness, assisted reproduction and genetic research, and need to be tempered.

CHANGING EXPECTATIONS AND PRIORITIES

Justifying a medicalized view of disease by asserting the altruistic vocational nature of the medical calling has been increasingly challenged. The paternalistic model of medicine, where the expert doctor manages the compliant patient and their disease with minimal negotiation, has been cast as an oppressive abuse of power. The call to understand the doctor-patient encounter from the point of view of the patient, the patient's carers and non-medical professionals has become difficult to ignore. Concomitant demographic and economic changes have made the need to incorporate patients' view more urgent. Chronic conditions have taken over from infectious disease as the main burden of disease for the population and therefore the main work of healthcare providers, and as life expectancy has increased so too have people's expectations of quality of life and of health services. People expect to live longer than their grandparents did and to receive good services from the NHS if and when their health fails.

Medicine's difficulties in responding to an apparently unending increase in the demand for health services have been compounded by the anticipation that scientific medicine would be able to mend all ills. Astonishing innovations in some branches of medicine have occurred while other problems remain untouched by new medical techniques. Medical expertise, technology and research effort have tended to focus on health problems which are fixable, so organ transplantation and cardiac bypass are now routine operations. By contrast, conditions that are less amenable to medical intervention have received less attention and fewer funds. For instance, strokes are the biggest cause of disability in Britain yet does not attract the levels of funding associated with other diseases that affect smaller numbers of people. Defining the medical profession's priorities for curing or containing the sick and maintaining the healthy is not a simple task and remains one in which different branches of medicine may not agree with one another. In addition, the voice of the services user is increasingly expected to be represented in defining priorities on management boards of healthcare trusts and steering committees for research work.

To understand the relationship between medicine and society a first step is to appreciate both the complexity of medicine as an institution – its clinical, research and teaching functions – and the difference between the institutional interests of medicine and the motivations and aspirations of individual doctors working within the profession. Stories of individual, heroic doctors seeking to improve people's quality of life, and the cases of rogue, criminal doctors are together important in understanding the public's expectations of medicine. Nonetheless, it is the institutional questions that preoccupy this book as the legitimate and appropriate limits of medicine's remit now and in the future are considered. Should medicine concern itself with issues beyond the boundaries of what is currently the formal healthcare system? A compelling reason why medicine should look beyond the clinical is that the vast majority of ill health is treated beyond organized clinical care: people can maintain their health, develop symptoms, treat them and recover from illness without ever consulting a medical professional.

Lack of contact with a doctor does not mean that people have not drawn on medical knowledge: part of the power of modern medicine lies in its penetration of the whole population's understanding of illness. In our highly literate and knowledge-based society, where most people have access to radio and television and a growing proportion to the internet, e-mail and mobile telephones, medical knowledge is widely accessible. Not only can ordinary people use medical handbooks and patient information systems, we can consult pharmacists, internet sites and NHS Direct. Information about health matters is not only provided for that crisis moment at the onset of an illness, but also as entertainment in dedicated newspaper and magazines pages and as part of regular broadcast scheduling. The means of accessing medical know-how may be diffuse, and largely independent of face-time with a doctor, but it is nonetheless a medical understanding to which most of us turn when illness strikes. Critics have described how medicine has accrued responsibility for an ever widening range of social problems, with the medicalization of childbirth, madness, criminal activity and addiction seen as a sometimes inappropriate assumption of responsibilities, or more sinisterly as medical colonization. In this view medicine's interest in preventing disease, whether through genetic or public health intervention, cannot be welcomed wholeheartedly given the inevitable extension of medicine's influence to cover 'pre-patients' who are not (yet) ill.

Medicine is the central and most authoritative institution that deals with health and illness, as is shown by the widespread influence of medical ideas about the process, treatment and prevention of disease. Understanding how this professional authority has built up over recent history and its links with falling mortality rates and the evolution of other economic and social systems is the subject of Chapter 1. Despite various challenges to medicine, its power has persisted, as has been demonstrated by the perpetuation of a system of professional self-regulation despite high profile cases of serious

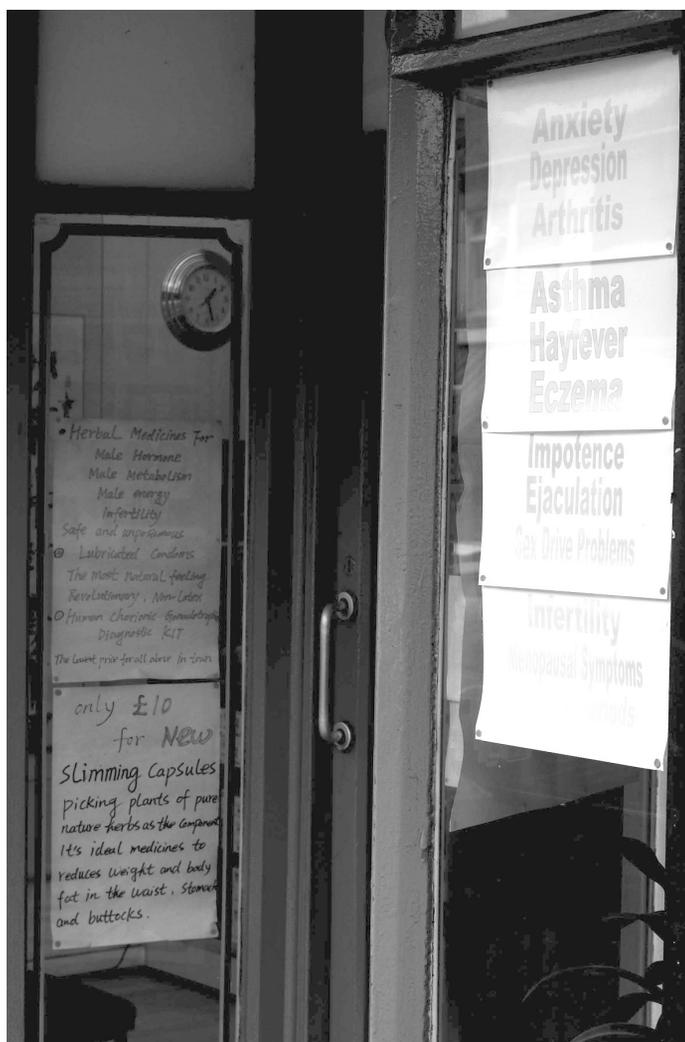


Figure 1 A large proportion of regular health care takes place outside the NHS and without recourse to the profession of medicine: people diagnose and treat their own symptoms, with informal help from friends or family as well as paid help from people without medical qualifications.

misconduct. The General Medical Council regulates professional conduct and it is doctors themselves who oversee and govern this process. While efforts to increase non-medical, lay representation on the GMC's governing body have been successful, it is nonetheless numerically dominated by doctors and has remained remarkably free of outside interference in its decisions about the fitness to practise medicine. Self-regulation has been the key to medicine's most important coup in assuring its own prestige and power: the idea that only doctors can stand in judgement on their fellow doctors rests on

the peculiar reverence with which medical knowledge is treated. The idea that non-medics cannot gauge, understand or intervene in the clinical relationship has, at least until recently, served to shelter medicine from the increasingly invasive system of outside inspection that accompanies other public sector professional practice. Medical regulation is currently undergoing significant reform (as discussed in the government White Paper, *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*, February 2007) and, while self-regulation is set to be modified, it has been important in understanding medicine's place in society today.

MEDICINE'S STANDING

While medicine has successfully limited the degree to which other professionals can judge its quality of practice, it regularly stands in judgement over others. Society relies on medical judgement for the regulation of various dilemmas and the extent of this reliance is an index of medicine's power. Medicine's jurisdiction extends well beyond medical matters since doctors testify during the regulation of aspects of public and private life, including judgements about criminal responsibility, the fitness to parent and eligibility to receive state benefits. These decisions have significant effects in terms of the level of intervention that is justified by public agencies into people's private life and the financial and material support which they are entitled to claim and medicine has been seen as being sufficiently trustworthy to wield this responsibility.

Belonging to a profession that enjoys high levels of power and prestige does not, of course, mean that individual practitioners necessarily enjoy happiness and contentment. Regret is often expressed for a recently passed golden age of medicine when the great autonomy of, and respect for, doctors made the job more satisfying. Doctors' individual autonomy has been eroded, with the upsurge of quality audits and non-medical management structures and the increasing access that ordinary people have to medical knowledge through old and new media. At the same time the range of things that doctors can do for patients has increased while expectations have been raised, all of which may have contributed to expressions of discontent by doctors. The debates about terms and conditions of employment for doctors is part of a wider debate about medicine's place in society: what can doctors expect of their patients and of the general population whose taxes pay their salaries? What can individual patients expect in return and how is the contract between society and the medical profession to be regulated? Should the special nature of medical work, the unsocial hours, the painful emotions and the proximity to death and disease, attract high financial reward? Or should the work be its own reward? Can patients' viewpoints be meaningfully included

in healthcare decision making? Given the emphasis on preventative work and consumer choice, is it still appropriate to refer to 'patients', or should the term 'clients' be used?

CRITICAL APPROACHES TO HEALTH AND MEDICINE

In order to begin to answer these questions we will start by defining the scope of the work that doctors undertake. Describing what doctors do is no mean feat in itself, given the breadth and variety of tasks undertaken by medicine: from laboratory-based histopathology to public health education campaigns; from ophthalmology to forensic psychiatry. At our disposal we have a tradition of sociological research that offers various approaches to analysing what happens at the individual level between doctors and patients and at the collective level between the profession and society. Sociology examines how social situations are structured by social class, ethnic group and gender which may, for instance, influence how a patient is treated in the health services. Sexism and racism are two of the ways that prejudice and discrimination systematically disadvantage particular groups. Common-sense explanations have often justified the poor conditions of women or minority ethnic groups in terms of those groups deserving their own misfortune, whereas a sociological approach looks at how those in power benefit from such inequality. Research into the meanings that influence our daily lives shows that illness is redolent with meaning and interpretation that do not rely on scientific models of causation. For instance, seizures have been associated with supernatural possession, which in some cultures has implied special visionary powers but in others has been seen as a bad omen leading to the shunning of the affected individual. To be diagnosed with epilepsy is still to be faced with the prospect of stigma, despite the condition being understood as a neurological condition that is treatable. Negative assumptions have not disappeared in the face of neurological explanations of the patterns of brain activity that cause seizures, because prejudice is not simply or straightforwardly a result of ignorance. Stigmatising views, as with other cultural evaluations, are often assumed and implicit and may only become obvious when they are disrupted. The implicit nature of culture's influence on our beliefs is part of its power.

Many of us would be reluctant to admit to adhering to superstition or 'old wives' tales' but would nonetheless be reluctant to walk under a ladder or put an umbrella up indoors for fear of bad luck, and would be similarly disinclined to 'speak ill of the dead'. The misfortune of illness is often explained in terms of luck rather than social inequalities and, especially in seeking to explain the onset of illness, non-scientific answers around destiny, fate, morality and spirituality are often invoked. Sociology is concerned with the structural distribution of resources that determine our material wellbeing and

the shared interpretations that give meaning to our lives. This attention to the shared, social aspects of life can appear to be somewhat at odds with medicine's focus on a treatable bodily pathology that is located in the individual.

How useful is this sociological view of the power and meanings around health and illness to doctors when actually faced with patients? This book considers medicine's deficits and shows how many of them derive from having excised the spiritual, personal and contextual aspects of illness and suffering from the clinical encounter. A patient who consults a doctor wants symptoms attended to and the underlying condition treated, while the doctor's duty of care is to that individual person. If the doctor-patient relationship is contracted on a one-to-one basis, how useful is it to consider the wider context in which the consultation is situated? The patient may be identified with a particular ethnic group, gender and socio-economic class and this identification could place the patient in a statistically high-risk group for a specific condition. Is it useful to a clinician to know about inequalities in the incidence and outcome of disease in sub-sections of the population? Is it relevant to the quality of one-to-one care?

It might be argued that providing the doctor does his or her best for each individual patient, it matters not one iota whether that patient is, for instance, black, nor that black minorities tend to receive poorer treatment compared to other ethnic groups. The social dimensions of illness – the influence of socio-economic class, religion, ethnicity, gender, or sexuality – have been regarded as being of little concern to the practice of medicine, being more properly the business of social workers, politicians, policy specialists, activists and academics. But such a view is disingenuous, since, despite the individual focus of much clinical care, preventative interventions such as immunization and screening, which are at the heart of the modern medical mission, are aimed at the wellbeing of the population rather than the individual. State-funded health services ensure the supply of employable workers and reduce the burden of disease and disability on the public purse. Medicine addresses population health problems both in terms of individual clinicians administering public health policies and by acting as gatekeepers for benefits aimed at alleviating the suffering of disability, chronic conditions and ensuring healthy pregnancy. What then is the doctor's obligation towards the population rather than the individual? Is there any responsibility or even requirement to practise in a way that addresses the social inequities in health? Should doctors' practice be aimed at society's overall health by aiming to reduce differentials?

Medicine has a long tradition of campaigning reformers working for the betterment of others by reducing the effect of inequalities through political as well as medical means. The Quaker physician John Coakley Lettsom (1744–1815) used some of the fortune made from his London medical practice on philanthropic activities and, more recently, the General Practitioner Julian Tudor Hart (1927–) worked in a mining village in South Wales to improve living conditions as well as to treat illness. Tudor Hart's description

of the inverse care law, whereby those most in need of healthcare receive the poorest service, has been important in directing efforts to tackle inequalities in mortality (see Chapter 4). Using the influence and prestige of their discipline, some doctors have seen their job as addressing, if not redressing, the consequences of the unequal distribution of power and money. Doctors have played a significant role in describing how being born into poverty is associated with premature death and disease when compared to being born into wealth (see Chapter 4). One of the ways that social class influences the risk of premature death is through its association with the available avenues of education and employment open to a person.

INEQUALITY WITHIN MEDICINE

Professionals, including doctors, make up the social classes associated with the lowest mortality rates. Despite the NHS and the Welfare State having been established for more than fifty years, class-based inequalities in health still persist. Despite medical education being state-funded and open to anyone, the medical profession remains structured by class, gender and ethnicity. Although women now make up more than half of the annual intake of medical students, they are significantly under-represented at senior levels and in competitive specialities (for instance, after a concerted, nation-wide, effort to increase their representation, women still only occupy 6 per cent of consultant surgeon posts in England). People of minority ethnicity are also at a disadvantage, given that non-Anglo-Saxon names have been routinely de-selected as interview candidates for training places and employment. Thus the medical profession is still overwhelmingly white and middle class, with nearly a third of medical students having parents who are or were doctors. Middle-class white men, who as a group were the pioneers and beneficiaries of medicine's establishment as a scientific, rational enterprise, continue to be its most powerful constituent. These inequalities evident within its own ranks in turn raise further questions about medicine's obligations to promoting an equitable society.

Does it matter that one group is over-represented in sought-after medical employment? Does it matter that the lower social classes are over-represented in experiencing premature mortality? These are parallel questions about how opportunity and material wealth are distributed in society. Those with power and privilege have sought to justify their own position as having been earned on the basis of merit alone, and by blaming the less fortunate for their own plight. Medicine has indeed, at times, been complicit in the justification of its own privilege and it has participated in confirming the marginalized status of some groups of patients: for instance, the moral failings of unmarried mothers had been defined as a form of madness in the twentieth century and their incarceration in asylums was thereby justified; the low pain threshold of black

patients was used as a reason to limit analgesia for people with sick cell crises; newborns with Down syndrome were refused treatment and even feeding in the 1960s on the grounds that these were lives not worth preserving. More recently, people with HIV have been denied treatment altogether or have been given treatment in a punitive fashion. In this respect medicine is not especially wicked, but it certainly reflects the prejudices of wider society.

Evidence of discrimination and the failure to challenge prejudice does not set medicine apart from other contemporary professions. Medicine's tendency to reproduce prejudice against stigmatized groups must be set against the philanthropic and radical reforming traditions of providing healthcare for society's powerless in opposition to the mores of 'respectable' society. Contemporary defenders of medicine point to the value of the scientific method in moving medicine away from moralising medical judgements. Medicine's focus on the pathogen should mean that an intra-venous drug-user's HIV-related symptoms will be treated with the same dispassionate care and expertise as a haemophiliac who contracted the virus via the blood transfusion service. Science's claim to value neutrality has certainly helped to remove religious morality from clinical decision making, but prejudice can nonetheless be found in the delivery of care. The cost of scientific neutrality and the focus on objective diagnostic criteria has been to deny that the subjective suffering of the patient has a place in the medical setting, as will be explored in Chapters 6 and 7.

The paradoxes of modern medicine are fascinating. Medicine is a noble profession, which, in Britain, works in a nationalised service to ameliorate the conditions of the marginalized and also accommodates private consultations which command high fees sometimes for procedures which are cosmetic rather than therapeutic. Some of medicine's techniques have remained largely unaltered for centuries (bone-setting for example) and these exist alongside techniques that rely on highly developed technology. Medicine insists upon the special individual nature of the relationship with the patient, yet pursues interventions to improve population-level health, which, in the case of screening and immunization, carry a level of risk for the individual. An important feature of medicine's rise, described in Chapter 1, is the demonstration of the efficacy of its methods: antibiotics can arrest the progress of previously fatal infections and immunization programmes will prevent the infections even arising. The decrease in mortality rates and the increase in longevity that have characterised the twentieth century have together been seen as triumphs of scientific medicine's methods.

PARADOXICAL MEDICINE

However, the extent to which medicine's ability to intervene in disease processes has been responsible for the increased longevity of the population as a whole

continues to be debated. While improvements to nutrition and housing in the first half of the twentieth century were crucial to improvements in the population's health, the medical administration of antibiotics and other newly developed drugs also played a role. Certainly the overall effect helped to establish medicine's increasingly scientific approach as effective and reliable. The public's trust in the great potential of medicine to improve quality of life was a necessary condition for the post-World-War II expansion of health and social care services. Throughout the twentieth and into the twenty-first century these developments have continued to accrue and technology that was unknown in medicine only a century ago is now routinely deployed: ultrasound scans, magnetic resonance imaging (MRI) scans for diagnosis and battery-powered brain implants to stimulate or suppress specific bodily functions. The process of disease at the genetic and molecular level has become a standard element of medical training and information about disease at the cellular level is regularly communicated to patients: the effects of chemotherapy on lymphocytes; testing for T-cell levels in people with HIV; the examination of individual gametes in assisted reproduction. The sub-cellular level of analysis, as in genetic testing where specific sequences of DNA are sought, is becoming more usual. The range of diagnoses that can be made continues to expand, as does the variety of therapies and treatments available. And yet, alongside technological and therapeutic innovation, other aspects of medicine have remained fairly constant: the UK continues to have a community-based network of General Practitioners (GPs) or family doctors who deal with bodies rather than cells and where examination and intervention are fairly low-tech. The common cold, flu and backache which account for the majority of days off work continue to make up much of a GP's caseload, where diagnoses remain largely based on the history that the patient offers.

And this brings us to a problem: medicine is a rapidly developing discipline that nonetheless retains much of the longstanding character of its practice. The breadth of the activities that medicine encompasses can make it difficult to discuss 'medicine' in the singular. Medicine is a dynamic and heterogeneous profession with such diverse clinical, research and academic practices that we might ask whether it is legitimate to discuss medicine as a single enterprise. It is difficult to prescribe what it is to be a doctor or, indeed, what might be the common features of doctors' work (see Chapter 2), so is it legitimate to analyse medicine as a single profession? Medicine considers itself and is considered by others to be a unified whole, and to a remarkable extent it behaves with a unity of purpose. That is to say, we all recognize what a doctor is even if we find it hard to offer a convincing definition or an adequate and succinct description that covers everything that a doctor might do. The doctor exists in our shared culture as a figure recognizable by his or her stethoscope, bleeper or scrubs, and is expected to be a useful, caring person who deals with illness. One of the markers of medicine's phenomenal success is that a caring, competent doctor is internationally recognized as a social good, cutting across language barriers and cultural divides.

OVERVIEW OF THIS BOOK

The paradoxes raised in this introduction together represent the subject of this book. Chapter 1 relates the current context of medicine and its role in society to recent historical developments. The challenge of defining what doctors do, and how this relates to patients' expectations of medicine, is considered in Chapter 2 and further developed in Chapter 3 as the medical definition of disease is compared with how lay people understand illness and health. The second part of the book explores the processes and experience of getting ill. Chapter 4 covers the body of evidence suggesting that the onset of illness is not a purely random matter, with people who live in disadvantaged conditions in terms of income, housing, employment and education consistently having the least favourable patterns of morbidity and mortality. Rates of ill health and of death are structured by socio-economic inequalities and yet there is a persistent emphasis on lifestyle and risk whereby an individual's behaviour is held responsible for the maintenance or breakdown of that person's health. The correlation between specific behaviours and the risk of disease has become a central tenet of health promotion and public health. The ubiquity of risk as an idea that informs health and its status in modern life more generally is the focus of Chapter 5.

Illness involves not simply individuals who may feel the stigma and failure of being ill, but also the families, friends and supporters who undertake their care. The effects on social networks of illness in terms of the physical and emotional labour of caring work is the subject of Chapter 6, which also deals with the sense of impending mortality that illness carries and about which medicine has little to say. This line of enquiry is extended in Chapter 7, which looks at the challenge which ill and dying bodies present, especially bodies which seem to be uncontrolled and uncontrollable by medical or other means. Chapter 8 focuses on disability, to ask how we can develop ways of understanding disability that more closely reflect how people experience it and how we may also avoid negative assumptions about people's inabilities.

Part 3 considers how organized healthcare provision responds to the challenges described in parts 1 and 2. The doctor is an important resource for ill people but the general crisis of faith in science and the professions, and a specific series of medical failures and abuses, have led to concern over a diminution of trust in doctors. Evidence of this damage to the doctor-patient relationship and the consequences of a reduced respect for and trust in medicine are discussed in Chapter 9. In terms of society's relationship with medicine, the organization and funding of the NHS, as successive governments attempt to improve general health and quality of care without losing control of spending levels, are dealt with in Chapter 10. Chapter 11 makes an assessment of the various challenges to medicine's autonomy as a profession, its role in defining and diagnosing disease and its dominance in the field of healthcare, and weighs up likely future changes. The concluding chapter offers a few practical steps that

doctors in their clinical practice can take to respond to some of these challenges. The development of medicine's professional profile as an institution able to respond to the ever-changing demands of society has depended on an ability to reflect upon the mutual responsibilities of the providers and recipients of healthcare. No simple formula exists for deriving this contract but a reflective, mature medical profession needs to be involved in an active and constant search for the best available consensus in order to avoid being outdated.

Using this book

Each chapter in this book has summary points at the beginning to give the reader an overview of what is about to be covered. Revision questions at the end of each chapter prompt the reader to recap the key points of the preceding chapter. Extension questions use the ideas in the chapter together with new material to ask about novel situations. There is also further reading indicated at the end of each chapter, where the interested reader can get a fuller and more detailed picture of the issues described in the chapter.

Further reading

Armstrong, D. (2003) *An Outline of Sociology as Applied to Medicine (5th edition)*. London: Arnold.

An influential and authoritative account of the significance of sociology's insights for medicine.

Lantos, J.D. (1997) *Do We Still Need Doctors?* New York: Routledge.

A provocative and readable book which introduces many of the dilemmas that face medicine in its relationship with the public; most of the evidence presented is from north America.

REVISION QUESTIONS

- 1 Are medicine's institutional obligations to the individual patient, or to the population that it serves?
- 2 Are individual doctors' obligations to the individual patient, or to the population that he or she serves?
- 3 Which groups need to be involved in setting priorities for research and service provision in healthcare?

EXTENSION QUESTIONS

1 Hierarchies within medicine

- Working with others, list all the specialities in medicine you can think of, in no particular order.
- Can the various specialities be divided by status? How is a high status specialism distinguished from a low status specialism? Are hospital doctors higher or lower status than community doctors? Is salary level more or less important than the specialist techniques that a doctor must learn to employ? Does the potential that a doctor has to improve someone's quality of life make a difference to the status of a specialism?
- Thinking about the esteem in which specialisms are held by other doctors, rank the specialisms that you've thought of in a single hierarchy.
- Rank the specialties in terms of the relative salary that each attracts.
- Are the rankings of esteem and of salary the same?

Compare your rankings with information given on remuneration and working conditions in the following book: Ward, C. and Eccles, S. (2001) *So You Want To Be A Brain Surgeon? (2nd edition)*. Oxford: Oxford University Press.

Are there any discrepancies between your rankings and the information in the book? Is it appropriate that different forms of medical practice attract differential financial reward? Is it appropriate that specialists in public health, palliative care, histopathology and thoracic surgery are all regulated by the same structures and legislation?

2 Feminised medicine?

At least 50 per cent of the intake for medical schools in the UK is now female. However, while the numbers of women consultants have risen, the numbers in some surgical specialities have dropped. There have been very few women presidents of Royal Colleges.

- What is preventing women from progressing up the ranks of all the specialisms of medicine?
- Should gender equality in all sections of the profession be a goal of twenty-first century medicine?
- Paid maternity leave and the provision of pre-school childcare (largely private sector) have not resulted in gender equality in the medical profession (or in many other professions). What further structural changes need to occur to permit women to succeed and reach the top of the medical profession?

