

The health care dilemma or 'Am I kranken, doctor?'



The cover illustration shows Guiseppe Balsamo peddling his 'elixir of life' in the eighteenth century. As an archetypal charlatan from the humblest of backgrounds in Palermo, he amassed such a huge fortune through his promises of eternal wellbeing from his nostrums that he and his prostitute wife could eventually pose successfully as an Italian Count and Countess. It is recorded that 'few men ever had a more powerful bedside manner'.

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3 Introduction

For the past 25 years the problems of the National Health Service in Britain have been considered primarily in terms of a shortage of resources. This emphasis has persisted in spite of National Health Service expenditure having doubled in real terms and in spite of huge increases in most grades of manpower. The number of doctors working in the hospitals, for example, has also doubled since 1948. Against this background, the point has been reached when it is necessary to consider whether there is not a more fundamental underlying cause for the apparently perpetual 'shortage' of medical care. This paper examines the basic concepts of health and ill-health from which the constantly increasing demands for medical care arise. It does so from a distinctive viewpoint which ONE recognises is not universally shared. This viewpoint is based on the belief that government-funded medical care should be essentially rational. Hence ONE argues against the provision of very costly and sophisticated treatments which can be shown to be ineffective in scientific medical terms. It argues that, if such treatments could be avoided, the resources so released could be used instead to make up the obvious shortfall in fields such as the care of the elderly, the chronic sick and the mentally handicapped.

The other viewpoint, which ONE rejects, is that any expressed demand for medical care – however irrational – represents a valid need in social (if not medical) terms, which should properly be met by the National Health Service. This belief is sincerely held by many people, but the discussion in this paper attempts to describe why such a philosophy leads to a misallocation of health care resources. It suggests that the public, the professions and the policy makers need fundamentally to redefine their objectives. To do this, they need to develop a different and (in the view of ONE) a more appropriate attitude towards ill-health than exists in society at present. First, however, it is necessary to look clear-sightedly at the nature and causes of ill-health as they manifest themselves at present.

The nature of ill-health

In the 1930s and 1940s, sickness was regarded as a fairly simple phenomenon. For example, one 'caught' or succumbed to an infection, and developed an illness which could usually be exactly diagnosed. The acute symptoms obviously needed treatment, and in the meantime the existence of the disease justified the individual concerned withdrawing as an invalid from normal social and economic activities. Now, however, it is

realised that the process is by no means so straightforward and that the distinction between health and ill-health is by no means as clear-cut as was assumed in the 1930s. Infectious diseases such as tuberculosis, poliomyelitis or measles provide good examples with which to illustrate the nature of the problem.

During the 19th and early 20th century, tuberculosis was endemic in Britain. Everyone was exposed to infection from the tubercle bacillus, although roughly four-fifths of the population suffered no identifiable symptoms from the encounter. They merely developed varying degrees of resistance to the bacteria as a result of their primary infection. However, the other one-fifth of the population developed clinical symptoms of tuberculosis from which disease most of them sooner or later died (OHE, 1962).

Similarly, poliomyelitis was endemic and in the relatively insanitary conditions of the 19th century the great majority of children had been infected with the virus in infancy and, again mostly without identifiable symptoms, had developed natural immunity to subsequent re-infection. It was only in the relatively more hygienic environment since the 1930s that a significant proportion of children reached adolescence without having developed natural immunity. At this later age a proportion of those first infected by the poliomyelitis virus developed the characteristic serious or fatal paralysis (OHE, 1963). Once again, however, by middle-age virtually everyone had experienced infection and, while a few had developed serious signs and symptoms of the disease, the great majority had responded merely by developing an immunity.

The third similar example is measles. In this case, the disease is so highly and obviously infectious that most people developed immunity early in life following a confirmed clinical diagnosis of measles. However, once again a proportion of the population developed only minimal and unrecognised symptoms when they were infected, although almost everyone had developed natural immunity to the disease by the time they were adults.

In each of these cases, therefore, the relevant question is why some people developed the disease while others, faced with a similar bacterial or viral challenge, apparently escaped the characteristic symptoms and diagnosis. There are, of course, two parts to the explanation. First, the extent and virulence of the infective challenge may vary greatly. If a person is exposed to a small dose of relatively non-virulent bacteria or virus, he is likely to develop minimal symptoms but nevertheless to establish effective immunity against all subsequent infection.¹ On the

¹ This is, of course, the principle involved in vaccination.

other hand, if the first challenge he faces is a massive exposure to a highly virulent strain he is likely to contract the disease.

The second consideration is the constitution of the individual and his physical and mental state when he is infected. It can be postulated that if one took 100 people, none of whom had any natural immunity to a particular infection, and administered to each a carefully calculated standard dose of bacteria of uniform virulence, some of the 100 would contract the disease while others would escape its symptoms and instead merely develop immunity to subsequent infection. The individual response would no doubt be influenced, for example, by the person's genetic and nutritional history and by his physiological and mental state at the time of the challenge. In particular, his degree of 'immunological competence', that is the inherent ability to fend off the invading organisms, would be a dominant consideration.

Obviously a human experiment to confirm this hypothesis would be unethical. However, there is useful support for it from the concept of the 'LD 50' as applied in toxicological experiments in animals. The LD 50 is the dose of toxic substance which proves lethal to 50 per cent of animals to whom it is administered. The animals are as far as possible of comparable age and genetic and nutritional background. Nevertheless, one half are able to accept the toxic challenge and to recover from it, while the other half die from the identical dose. This individual variation between animals must be mirrored in similar variations in the human response to toxic environmental challenges.

It is a hypothesis of this paper that this situation which has been described and which is now undisputed in respect of infectious diseases applies to a very wide spectrum of other diseases also. That is, in the case of each individual challenge which a human being faces there is an interaction between the character and degree of the challenge on the one hand, and the mental and physical state of the individual on the other. It is the result of this interaction which determines whether the person adapts to the challenge and continues to function adequately or succumbs to it by developing clinical disease. It is only in a very small number of cases, such as spina bifida or juvenile diabetes, that the disease process can be explained solely in terms of an inherent inadequacy in the body.

The rheumatic diseases provide another illustration of this hypothesis. Undoubtedly rheumatoid arthritis, osteoarthritis and gout exist as disease entities in the sense that an identifiable clinical picture can explain perceived symptoms. However, the symptom of pain caused in the three diseases by inflammation,

6 physical joint damage and deposits of uric acid respectively is necessarily assessed subjectively by the patient. Someone with a low pain threshold will report symptoms for which a physical explanation in terms of rheumatic disease may be offered by their physician. However, in reality the patient's physical condition may be well within a normally tolerated deviation from the accepted state of 'good health'. The diagnosis in this case is based on the patient's symptoms rather than on his physical condition. Other people with a very much higher degree of measurable physical abnormality but with a higher pain threshold might report no symptoms and indeed may experience none. Moreover, the subsequent course of the disease may be influenced as much by behaviour patterns as by inherent deterioration in the body. In osteoarthritis, for example, an abnormal gait to minimise initial discomfort may easily aggravate joint damage and speed up the progress of the disease. The effect of diet on the progress of gout has long been recognised. Against this background the concept of the presence or absence of molecular abnormality associated with the disease becomes meaningless in the majority of situations. Furthermore, the prognosis of the condition, with or without treatment, not only hinges partly on the anatomical localisation of physical abnormalities precipitated by the underlying molecular abnormality, but also on the subjective response.²

This emphasis on the importance of a subjective response is perhaps unfashionable in the 1970s. It was, however, more familiar in the days before it came to be mistakenly believed that most disease could be explained simply in physical or chemical terms. George Cheyne in the 1720s and James Johnson in the 1830s, for example, each referred to the influence of the state of the body and the mind and of the organisation of society on the development of physical illness. Johnson, writing of 'pulmonary consumption' (45 years before Koch identified the tubercle bacillus) described four stages of the disease. The first he called a 'constitutional predisposition'. 'In this preliminary stage or condition, tubercles are formed or forming' he wrote. Incidentally, this is a clear 19th century reference to the existence of presymptomatic disease. In the second stage of consumption, he described how the symptoms become apparent – the cough and 'a disposition to chilliness'. In the third stage he reported that the expectorations 'begin to present specks of white or yellow matter, showing that some of the tubercles have acquired size'.

² In the case of rheumatic disease this comment applies particularly to rheumatoid arthritis and gout. Osteoarthritis – representing mainly a mechanical failure – may not have a primarily molecular cause.

In the fourth stage the patient is moribund. Perceptively, Johnson gave the opinion that in the first stage, despite the fact that the 'tubercles are formed or forming', the disease could be pre-empted by 'improving the general health'. Healthy behaviour, he said 'will frequently render the soil, as it were, unfavourable for the growth of tubercles'. He was describing, intuitively, the fact that the majority of people infected by the tubercle bacillus nevertheless failed to develop overt clinical symptoms.

Turning again to the rheumatic diseases, as late as the 1930s the concept of 'psychogenic pain' provided a fashionable explanation in cases where a rheumatic disease would now probably be diagnosed. This present fashion among patients as well as doctors for a specific diagnosis in all cases of ill-health, if possible based on a physical or chemical observation, is one of the root causes of the current problems of medical care in the western world. It is arguable that the provision of medical care would be more rational if it were accepted that some of the multifactorial causes even of the apparently straightforward diseases are still frequently unrecognised or misunderstood.

The process of becoming ill

In parallel with the mistaken idea of the 1930s and 1940s that the presence or absence of disease could be specifically defined, it was assumed that an individual's decision on whether or not to seek medical advice and the doctor's decision on whether or not to prescribe treatment would be equally clear-cut and rational. Thus it was believed that, if the barriers created by the payment of medical fees were removed, the provision of medical care would accurately reflect scientifically defined medical need. Much evidence, however, has pointed to the fallacy of this assumption. Successive surveys have shown that the WHO definition of health as 'as state of complete physical, mental and social well-being' is totally unrealistic. About nine out of ten people have been shown to experience some symptoms in the course of any two-week period – on average four symptoms each (Dunnell and Cartwright, 1972). Further studies have shown that the decision on whether or not to seek medical advice for these symptoms is strongly influenced by social and psychological factors (Taylor, 1968; Robinson, 1971).

This introduces the first major anomaly in the process of becoming ill. The individual who has severe symptoms and who would be found to have obvious signs of disease if he consulted his doctor will continue to be regarded as 'healthy' if he fails to consult. People may, of course, diagnose themselves as having a

cold or influenza or as suffering from food poisoning or hay fever. However, such 'diagnoses' in reality represent no more than a shorthand description of the symptoms. Commonly, with conditions such as blood pressure, diabetes or anaemia, or more rarely with conditions such as multiple sclerosis, Parkinson's disease, or porphyria, the disease formally comes into existence only when a physician has pronounced it to be present. The doctor gives his patient a label of the disease when he makes the diagnosis. The patient in consequence will shift, for example, from a statement such as 'I don't feel too well' to 'I've got blood pressure'.

This would not matter if the presence or the absence of clinical disease were unambiguous. However, it has been pointed out that this is not so. Thus if the doctor observes a physical or, more often, a biochemical 'abnormality' (in the sense that the patient's reading varies significantly from the statistical average for the population) the doctor faces a dilemma. If he tells the patient his tentative diagnosis, the patient may return home in the belief that he is suffering from a potentially serious illness. If on the other hand the doctor remains silent on the matter and merely makes a note in his own records, the patient will believe himself still to be healthy and free from disease.

This Hippocratic authority of doctors to decide whether or not to confer a disease on their patient has been surprisingly little discussed. There has been even less discussion about the effect which such a decision may have on the patient's prognosis or on the national economy.

In the case of a serious diagnosis, the mere awarding of the 'diagnostic label' to the patient may convert what the patient previously considered to be a set of troublesome symptoms into a catastrophic medical disaster. In diseases where psychological elements are likely to have a strong influence anyway, the diagnosis may itself adversely affect the prognosis. The continuous state of subsequent anxiety, in anticipation of a further deterioration, not only directly impairs the quality of the patient's life but may indirectly accelerate the progress of the disease itself.

While this ethical dilemma faces a doctor in the case of a dramatic diagnosis, a very important but much neglected economic problem arises with the more mundane diagnoses. When a doctor, by his diagnosis, translates an 'ordinary smoker's cough' into 'bronchitis' he has probably created a lifelong chronic illness. Similarly, he can do so with a case of dyspepsia caused by persistent dietary indiscretion if he translates it into a 'suspected peptic ulcer' or a 'grumbling appendix'. In both situations, the first was an irritating condition with which the patient had formerly expected to live as best he could. The

second has become a specific, if hypothetical, medical condition which will be regarded as a justification for continuing health service care and perhaps repeated absences from work. By making the diagnosis the doctor has not only created a case of chronic and officially recognised illness, but may perhaps also have thrown away an opportunity to promote positive good health by educating the patient to give up smoking or to improve his dietary habits. The patient's unhealthy life-style may in his view have been legitimised by an overtly medical explanation of its consequences.

'The clinical iceberg'

In 1963, when *The Lancet* published Last's paper on undiagnosed diseases, which the editor had titled '“The Iceberg”'; completing the clinical picture in general practice', it was generally hailed as revealing huge areas of unmet medical need, and hence as a severe indictment of the inadequacies of the National Health Service. For example with bronchitis, there was widespread criticism that many cases, such as the 'smoker's cough' referred to above, remained undiagnosed and hence were denied the 'benefits' of formal medical care. It has only more recently been realised, for the reasons described, that although the iceberg certainly exists it has no finite dimensions. Hence attempts to bring it above the surface merely exacerbate the already apparently inexhaustible demands for additional medical care. As public expectations of good health in the WHO sense extend, and as advances in medical technology make the discovery of statistically defined 'abnormalities' simpler and more widespread, one is liable to reach a situation in which it would be normal for every individual, at least past middle-age, to be labelled with numerous diagnoses, all of which would be regarded as requiring on-going medical treatment. The healthy patient would then merely be one who had not been properly investigated. Good health, defined on this basis, would have become a highly abnormal state.

This situation has in fact been described in purely statistical terms by Bradwell and others (1974). They pointed out that if the conventional medical definition of a statistical 'abnormality' is accepted, 5 per cent of any population will automatically fall outside the 'normal' limits - i.e. will be medically abnormal. On this basis even if as few as 15 tests are performed on a patient, it is more likely than not that at least one of these tests will result in a statistically 'abnormal' result. Furthermore, the study which Bradwell's paper was describing showed that the problem was

accentuated because with hindsight it was realised that many of the conventionally accepted 'normal' values did not in fact accurately reflect the statistical average for the patient's particular age and sex group. Thus, out of 200 patients with unexpected and unexplained 'abnormal' results in the original survey only three were found subsequently on a five-year follow up to have developed a clinical disease which could have been predicted from the observed 'abnormality'.

Hence the misconception underlying the concept of the clinical iceberg has aggravated the problems which have already been described. The fact that an individual is physically or biochemically abnormal in a purely statistical sense should not rationally be taken as a basis for a specific diagnosis or as an explanation for his equally subjectively assessed symptoms. Yet this is what the concept of the clinical iceberg has tended to encourage. A raised blood pressure, a raised blood sugar or a depressed haemoglobin level have been too readily accepted as 'rational' explanations for symptoms to which they may be wholly unrelated. Indeed, diseases such as hypertension, diabetes and anaemia are probably being over-diagnosed instead of being under-diagnosed as the concept of the iceberg implied. The results of many randomised controlled trials – showing no benefit from treatment after diagnosis for such diseases – indicate that this is in fact the case (Cochrane, 1972). In the search for the chimera of perfect well-being, health care resources are being squandered on treatments which in medical terms are unnecessary and ineffective. The basic reason for this is that the indistinct nature of present-day 'ill-health' and the irrationality of the process of 'becoming ill' have so far gone largely unrecognised. Thus the problems of the National Health Service may flow largely from a misallocation rather than an overall shortage of resources. The obvious shortfall in the 'caring' services needs to be seen against a background of sometimes over-enthusiastic provision of sophisticated 'curative' medicine.

Psychological factors

The problems of interpreting the significance of physical or biochemical measurements and of realistically assessing the significance of experienced symptoms are further complicated by the effect of social and psychological factors in the definition of ill-health. Psychosomatic illness is now a well-recognised phenomenon and pioneers such as Balint (1957) have done much to make family doctors aware of the need to look at the 'whole person' in deciding on a diagnosis and treatment.

In the most straightforward cases, diseases such as asthma, eczema and 'nervous dyspepsia' have long been known to include a psychological as well as a physical component. In the last case, the patient may literally be 'belly-aching' about some personal anxiety or discontent when he presents his gastric symptoms to the doctor. Similarly, backache and dysmenorrhoea may be caused more by mental than by physical factors. A case has been reported, for example, of a woman who was due to undergo spinal surgery when her general practitioner belatedly found that her backache was caused by anxiety surrounding her impending marriage rather than the physical 'abnormality' observed in the X-ray plates by the orthopaedic surgeon. Her symptoms disappeared without physical intervention when her problem was frankly discussed with the doctor (Pasmore, 1972).

In childhood, also, psychological factors may often be responsible for physical symptoms. Recurrent gastric pain, for example, has been successfully relieved by simple psychotherapy rather than by medicine or surgery (Apley and Hale, 1973). In other cases it has been shown that a foreboding of certain school activities can precipitate the occurrence of symptoms on days when these activities are due to take place (Pickering, 1974). In such cases, if the psychological factors are not recognised there is a risk that the therapy prescribed may be inappropriate, uneconomic and potentially harmful.

Apart from these well-recognised examples, however, there is now a suspicion that some of the more serious physical illnesses may often have an underlying psychological basis. In classical literature tuberculosis was characteristically the disease of tragedy, and it seems possible that this reflected a true causal relationship in some cases. Although evidence is lacking, there is a suggestion that the same might be true now with the cancers. In more practical terms, however, there is important evidence that there is significant psychological or mental involvement in diseases such as hypertension.

According to traditional medical theory, blood pressure was controlled by the autonomic nervous system and was hence by definition beyond the control of the conscious or subconscious mind.³ Recent experiments, however, have shown that it is

³ In this context the 'subconscious mind' obviously refers to the unconscious CNS (Central Nervous System) mental activity (e.g. anxieties reflected in dreams, as in the classical Freudian interpretation) rather than to the equally unconscious ANS (Autonomic Nervous System) activity. The latter routinely controls body functions such as heart beat, kidney function and blood vessel tension, which between them, in turn, control blood pressure. As must be clear from the discussion, however, the two-way interaction between the CNS and ANS blurs any clear-cut distinction.

possible to achieve dramatic reductions in blood pressure by a process of conscious thought (Rachman and Phillips, 1975). Such experiments are described as involving 'biofeedback'. Patients can literally 'learn' how to bring their blood pressure down to healthy levels by being shown with the aid of instruments how relaxation can achieve this reduction. This is not dissimilar in principle to the practices of meditation, as taught particularly in the Eastern cultures. People, as it were, discover how their conscious mind can help them to be healthy without pharmacological or surgical intervention.

The medicalisation of social problems

One final factor has helped to aggravate the health care dilemma created by potentially unlimited demand superimposed on strictly limited economic resources. This is what can be described as the medicalisation of social problems.

A previous OHE publication (1974) has described what it called the pastoral role which many family doctors have tended in the last few decades to have taken over from the Church. Many now act as advisers, comforters and fathers confessor on a wide range of matters which would never previously have been regarded as medical problems. These include, for example, family strife, financial difficulties, dissatisfaction or insecurity at work, sexual problems and deviant behaviour such as alcoholism, violence or even straightforward crime.

Not all family doctors, and probably very few hospital doctors, consider these to be legitimate medical problems. Nevertheless, the general public seem to look increasingly to the medical profession for help in these fields. This trend has been fostered partly by the free availability of access to the family doctor and also no doubt partly because medical consultation – as opposed to a session in the confessional – confers a form of respectability on the patient's problem, in a sense which is discussed again later.

The difficulties which this situation creates are obvious. First, doctors have received scant training, if indeed any, in handling these sorts of social and personal problems. Many give intuitive and valuable advice; and over the years they may build up a body of experience and sympathetic understanding which will make them effective counsellors. However, this is a personal achievement and it is largely unrelated to their professional medical status or training, which in the eyes of the patient is what gives them the right and the authority to dispense this sort of advice.

Secondly, related to this, there are very different economic considerations when the doctor rather than the priest provides this social service. The priest is still rewarded primarily by the fulfilment of his vocational urges.⁴ The family doctor on the other hand, is a highly-paid professional. Furthermore, if he spends a large proportion of his time in this pastoral role it is inevitable that many of the more difficult among the purely medical problems presented to him may have to be referred expensively to hospital for the full examination which in other circumstances the family doctor would have had time to perform himself.

Thirdly, it throws the doctor back into the historical witch-doctor or shaman role. In so far as these problems will have moral overtones the doctor may have to dispense social rather than medical judgements. The patient may need and expect some stricture to rebuke him for his deviance or some comfort to console him in his personal inadequacy. Inevitably there is a risk that the doctor may subconsciously fall back on his specifically medical techniques in order to impose the necessary 'punishment' or to dispense the necessary consolation to his patient. The punishment could be some form of unpleasant therapy, while the consolation could be a psychotropic medicine. In either case, at doubtfully justifiable expense to the health service, the doctor has taken on himself the right to make a social judgement for which in logic he is unsuited. This problem is seen at its most extreme when a psychiatric opinion is sought by the defence in respect of a convicted criminal. The doctor in these circumstances has the power – over-ruling that of the judge – to pronounce the convict to be a criminal or an invalid.⁵ In a society in which the ultimate rewards of Heaven or the ultimate damnation of Hell are no longer taken seriously, it is a dangerous situation to allow anti-social deviants to escape too easily from the legal strictures of their society into a medically approved haven of invalidity. Conversely, there is the danger – epitomised

4 Those who crave for the rewards of Mammon have tended, appropriately enough, to leave the Church in order to seek their vocation in the social services.

5 Attempts by the legal profession to 'medicalise' their clients' crimes can have their lighter side. In a recent case at Chelmsford Crown Court where a 22-year-old Essex man pleaded guilty to stealing a car, going equipped for theft, damaging property, taking a car without consent, dangerous driving and driving uninsured – and asked for nine other offences to be taken into consideration – defence counsel explained that whenever his client felt depressed he would take a car like 'other people might take aspirin'. On one day he had taken no fewer than eight cars. Counsel's rather poor grasp of psychopharmacology in no way diminishes the significance of his attempted excursion into medical sociology. It was, however, unsuccessful in this case since his client was nevertheless jailed for two and a half years (Bresler, 1975).

by the stories emanating from the Soviet Union – that the medical establishment in too close sympathy with the State authorities could define norms of ‘healthy’ behaviour which allow socially or politically awkward citizens to be incarcerated for long spells in ‘hospital’.

If the medical profession continues to expand the social and moral authority which the public seem now to expect from them, one could eventually drift into a sort of ‘healthocracy’ corresponding to the theocracies of primitive society. Already when one looks at the huge and expensive hospital complexes in both the developed and the less developed countries, one is tempted to see them as technological temples, rather than as scientifically rational enterprises. The economic and social implications of this trend could recall the effects of the monumental use of labour to construct the Aztec or Egyptian pyramids and the forms of worship associated with them.

The underlying problem

From this description of the different aspects of the current situation it is possible briefly to analyse the underlying problem, and then to distil from it some principles on which to base future health care policy.

First, medical diagnosis in technological terms has shifted away from the identification of gross and apparently easily observable pathology. In the 1930s, the signs and symptoms of pneumonia, tuberculosis, the classical infectious diseases, appendicitis, ulcers and advanced tumours were relatively easily recognised and their diagnostic significance was usually unambiguous. Now, however, technical medical diagnosis often comes instead at the molecular level. In place of gross pathological signs, doctors are often seeking abnormalities in biochemical patterns. Not only is this generally more costly because it is more difficult, but the significance of apparent pathology at this level is a very great deal more difficult to interpret.

Furthermore, simply in terms of diagnostic resources, the economic implications of this shift have not yet been properly recognised. When a doctor’s diagnostic tools consisted largely of a clinical thermometer, a stethoscope, various optical instruments to see into the different orifices of the body and simple X-ray machines there was little difficulty in finding money to ensure their availability. Now, however, when potential diagnostic instruments include automatic machines capable of 20 or more chemical analyses on a single specimen and scanners capable of screening the whole body for early signs of carcinoma,

the situation has radically changed. These instruments may cost hundreds of thousands of pounds each and it is quite unrealistic to assume that a National Health Service could finance their general availability, or provide the technically skilled staff to man them.

This shift from gross pathological investigations to diagnosis at the molecular level, with the associated unlimited potential demands for economic resources, has occurred at the same time as a fundamental change in the attitudes of the public and the professions to ill-health. The encouragement of unrealistic expectations of well-being and the consequent continuous extension of reported morbidity has come together with an explosive increase in the scope for seeking physical or biochemical 'explanations' for the patients' symptoms. On top of this, the professional medical expertise of the doctors and the absolute power which this has conferred on them to pronounce the presence or absence of disease has led irrationally to a situation in which the public increasingly turn to them with other problems also. Unless the implications of this situation are recognised and tackled, it is inevitable that demand for medical care will continue to expand indefinitely and will invariably run ahead of available supply, however rapidly health care resources are expanded.

A more realistic definition of health

At present, as this paper has described, ill-health – or disease – is taken to mean the situation in which the patient experiences physical, mental or even 'social' symptoms and in which these are accepted as medically significant by the doctor. This state of 'ill-health' having been created in the course of the medical consultation, all too often the whole health care machine is expensively directed towards finding a rational explanation for the symptoms (a 'diagnosis') and a way of avoiding them (a 'treatment'). Furthermore, ill-health in this sense has become socially respectable and may in some cases bring benefits to the patient in legitimising a withdrawal from difficult or undesirable situations.

However, returning to the initial description of the nature of disease, one can regard ill-health in very different terms. It can be seen as a failure to respond and cope satisfactorily with the normal periodic challenges which every human being must face during his lifetime. These challenges may be the tubercle bacillus or the measles virus. They may be dietary indiscretions or

excessive smoking. They may be the often still unidentified carcinogens and causative agents responsible for diseases such as multiple sclerosis. They may be exposure to one of many allergens or toxic chemicals. They may be prolonged exposure to extremes of high or low temperature. Or they may consist of physical trauma as a result of many kinds of accidental injury. All of these are traditionally accepted physical causes of disease.

But on top of this type of physical challenge, there is also another type of challenge. These are the social or interpersonal problems which once again are a normal feature of human life; the family stresses, feelings of inadequacy in one's chosen employment or in one's social circle and self-imposed ambitions which in realistic terms are unattainable, for example. These social and psychological factors have been shown to be just as important determinants as genuinely medical factors in the decision to seek or not to seek medical care.

The problem which this paper is describing, and the key to its solution, may lie in the dichotomy of attitude towards social inadequacy – as represented by these social and psychological factors – on the one hand and to ill-health on the other. No one willingly admits that they have failed to achieve their social ambitions or to be successful in their career or to be a well-adjusted member of their family. Yet no corresponding stigma attaches to an admission of medically confirmed ill-health which could all too easily be used as an acceptable explanation for other apparent manifestations of inadequacy. This is the phenomenon which sociologists have described in terms of patients 'claiming the status sick'. Because this involves a fundamentally different concept of ill-health from that traditionally accepted in the 1930s the discussion of it would perhaps be clarified if a new word were to be coined to describe it. This might, for example, be a straight transliteration from the German 'kranken', and perhaps in future patients might end their consultation with the doctor with the question 'Am I kranken, doctor?' This would be a shorthand description for the underlying question, 'Are you going to legitimise my avoidance of normal social and economic activities by declaring me to be unwell?'

If ill-health were to be regarded in the same light as social or economic inadequacy this dichotomy could be eliminated. Ill-health is at present too often incorrectly seen as being an unavoidable and wholly excusable consequence of exposure to external challenges. It should instead perhaps be seen as a failure of the mind or body to adapt and to cope with the physical, psychological and social challenges which every human being must experience. When an individual claims a state of

ill-health and the claim is accepted by a doctor, the social and physical environment around him has, as it were, 'won' and he, as it were, has 'lost'.

Although this is an unfashionable philosophy at present, it is by no means a new one. A hundred years ago, Samuel Butler in *Erewhon* described a society in which those who contracted tuberculosis were convicted in the courts and sentenced to life imprisonment with hard labour. Butler's account of the judge's reason for such a sentence is not without relevance to the present situation in Britain in which demand for medical care appears unendingly elastic. He justified the punishment on the grounds that 'it was the only means of preventing weakness and sickliness from spreading'. Without such prison sentences, he concluded, there would be 'ten times the suffering now inflicted upon the accused'.

Butler, of course, was describing such a trial and conviction in *Erewhon* as a satire on the inhumanity of the Victorian treatment of convicted criminals – who in *Erewhon* received therapy rather than punishment. Nevertheless the philosophy underlying his ironic proposition should not perhaps be too lightly dismissed. Both the public and the professions could reverse the present trend towards a continued expansion of demand for health care resources if ill-health were less readily accepted as unavoidable and as being the responsibility of the health service rather than the individual. It is possible that at present the public are encouraged by the professions to seek too easily 'the status sick' or to become too readily 'kranken'.

Self-care

If ill-health is to be regarded as the failure of the individual to adapt to and to cope with the challenges to which he is inevitably exposed, there are clearly important implications for the professions and the public. Health needs to become primarily a personal responsibility and doctors need to educate their patients more explicitly in these terms.

Doctors need first of all to re-educate the public to accept that unwellness – in the sense of failing to achieve the WHO state of perfect well-being – is normal. They also need to revert to the concept that becoming an invalid represents a failure on the part of the mind or body. It is not always an inevitable event for which the rest of society must take the blame and bear the responsibility. In this context there may be great potential for the principles involved in the processes of biofeedback. There is also the much simpler principle of merely trying to live as healthily

as possible. This includes proper exercise, sensible diets, avoidance of excessive consumption of alcohol and, most of all, avoidance of cigarette smoking. Here health education in the broadest sense has an important role to play.

This new attitude would also necessitate teaching patients to avoid unrealistic expectation of either intellectual or physical performance, particularly in later years.⁶ It means helping patients to find job satisfaction in their work and relaxation in their family and social relationships. This involves something very different from the traditional perception of the role of the doctor in patient care; but it was explained in the early part of this paper that the pattern of ill-health which the family doctor now has to handle is also very different from that of the past.

Doctors must themselves also drastically change their attitudes. Clearly, from the discussion, the patient must be treated as a 'whole person' whether in general practice or in hospital. His work, his family, his status and his satisfactions may be just as potent an influence on the state of his health as any bacteria or inherent idiosyncracies in his metabolism or physiology. In turn, these idiosyncracies must be seen in perspective. The concept of a 'normal' human being which has been so firmly embodied in the teaching of medicine has done immeasurable harm. There is no such animal. Parameters as far ranging as body weight, height, haemoglobin, blood pressure, enzyme metabolism rates, kidney and liver function and the various facets of mental ability all vary tremendously as between one individual and another. It appears ridiculous on reflection that a deviation from the statistical average has in the past – as with anaemia – been taken to define the presence of disease. It is analogous to saying that the presence of multiplying tubercle bacilli necessarily defines the existence of tuberculosis. From the earlier discussion it was clearly axiomatic that for every individual there must have been some point of time in their life when the tubercle bacillus must have been alive and multiplying within their tissues. As Johnson put it, 'the tubercles were already formed or forming'. At that point, in bacteriologically defined terms, the individual had tuberculosis. Similarly, today, there must be few people with normal emotions who do not suffer from measurably elevated blood pressure during spells of frustration or rage. In both these cases, whether the body's immunological system has fended off a bacterial infection or the homeostatic cardiovascular mechanisms have brought down the blood pressure, the healthy

⁶ It is interesting in this connection to note the growth of health care clinics specialising in the treatment of top athletes, who expect their bodies to perform and to tolerate traumatic insults beyond all reasonable expectations.

individual has adapted to the challenge facing him and succeeded in overcoming it.

Finally, the health service must see more clearly its own role in the treatment of disease as it has been described. Too often in the past doctors have hailed as a great triumph the discovery of a new disease or the identification of a known one in yet another individual. The role of the health service should not be to create more disease in these ways. It should be to help individuals through the health hazards of their life, encouraging and supporting them to avoid their becoming invalids. Medicines will very often be essential in achieving this objective, although they should not be used merely as pharmacological crutches. General practitioners should also remember in particular that referral to hospital may sometimes lead to unnecessary admission with all the inconvenience for the patient and the misuse of health care resources which this involves (Ashford and Pearson, 1970; Royal College of General Practitioners, 1970).

Medical research, and more especially the advice to practitioners from pundits, also needs to take account of the whole person concept of medicine outlined in this paper. Over-specialised investigations and treatment and purist advice on therapy too often ignores the complex interactions between the physical and mental states of the individual and the physical and social environment in which he is operating. It also tends to ignore the importance of the relationship between the patient and doctor, and their respective attitudes to disability.

Doctors need to be sensitively aware of their responsibility in conferring diagnostic labels on their patients. Their ability to 'create' illness in this way is perhaps one of the most dangerous aspects of the doctor-patient relationship, based as it is on the traditional authoritarian role of the medical profession. It is perhaps necessary for doctors to be much more ready to withhold the 'status sick' and instead to instil a sense of greater self-reliance into their patients. The traditional stoicism of the Christian Victorian era was perhaps too extreme; but the apparently growing medical self-indulgence of the 1970s could be equally harmful in the other direction. The population has recently been educated to expect unrealistic levels of well-being, which ignore the inbuilt frailty of the human body, especially when faced with the various challenges which are an inevitable feature of human life. Furthermore, although health education is important, people cannot be expected always to be paragons in their pursuit of the 'healthy life'. Hence no society can expect to achieve a state of complete physical, mental and social well-being, however effective its health services may be. Once this

principle is more widely recognised it is possible that many of the existing 'shortages' under the National Health Service could be eliminated without the employment of additional resources.

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