

PERSONAL VIEW

Ivan Illich—an assessment from general practice

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Ivan Illich's book *Medical Nemesis* is assured of a wide and attentive audience, coming as it does at a time when economic conditions make it unlikely that the increasing appetites of medical technology can be sated. His criticism of contemporary medicine is in two major parts; the first being that medicine is ineffective and has little influence on patterns of disease, the second that it is positively damaging because it interferes with man's autonomy in dealing with his personal predicament, which in all cases includes the necessity of coming to terms with suffering and death. He concludes by linking the pre-occupation with professionally-administered medical services to our over-industrialised state, in which the benefits of technology are, he states, outweighed by the feeling of alienation and helplessness they have engendered within us.

There is some implied contradiction between these two fundamental criticisms since, if modern medicine is merely the charade that he considers it to be, its impotence should have been recognised by a sizable proportion of our society, and the numbers of those rejecting its ministrations and thus preserving their autonomy should be much higher than is the case. In countries where the health services are freely accessible to all, the alternatives to modern medicine have been muted and insubstantial. If we follow Illich's arguments we must consider modern medicine as either a masterful deception or a form of collective neurosis.

His criticisms, however, considered in more detail, have more force and vigour than his solutions, which seem to hint at some anarchic society in which people exist in relative self-sufficiency, in harmony with their means of production, and with clear understanding of their fragile and finite existence as human beings. Even for those who accept this as a desirable or practical aim, there are few suggestions to guide them towards the development of a de-mystified alternative medicine.

Illich emphasises that many infectious diseases had declined markedly, well before the advent of antibiotics, but neglects to mention that even though social and economic changes were mainly responsible for this, doctors did play an active part in determining the methods of preventing the spread of some of the common diseases. Although many of the infectious diseases had decreased in incidence over the years before the introduction of antibiotics, they still caused a serious mortality and morbidity in the population which were affected dramatically by the development of effective chemotherapy (Office of Health Economics, 1963).

It does not follow that modern medicine is ineffective merely because disease patterns improved before specific therapy became available, and he does not mention the advent of the controlled clinical trial which has made the assessment of new forms of therapy a much more rigorous affair than it was.

He also chooses to ignore the advances of modern surgery, and in the section headed *Useless Medical Treatment*, he does mention many conditions which he admits are helped by medical treatment! Similarly he does not discuss those diseases in which treatment, although not curative, has been shown to produce great functional improvement, e.g. disodium cromoglycate for asthma, and β -blocking drugs for angina.

Self-medication

He is, of course, correct to document the dangers of iatrogenic disease, but fails to state that some at least is caused by self-medication, and that self-induced diseases due to cigarette smoking or alcohol consumption are major causes of mortality not related to doctors' prescribing habits. The resistance of these habits to any advice about stopping them suggests that at least some people are quite able to maintain their autonomy against the blandishments of the medical establishment, and the rising rate of lung cancer in the USSR suggests that habits such as smoking cannot be explained purely as responses to advertising pressures (Zhuk, 1968). In discussing potentially toxic food additives and chemicals, Illich omits any mention of the problems that non-industrialised societies experience with dietary toxins, e.g. carcinoma of the oesophagus in Africa probably due to nitrosamines in local beers, aflatoxin causing hepatic carcinoma in Africa, ergotism due to fungal contamination of rye, and the probable role of cassava in tropical neuropathy.

The problem of pain

Illich feels that relief of pain and suffering tends to lead to a feeling of personal incompetence in dealing with life's problems, but I am unconvinced that pain, illness, and death were ever merely a personal dilemma for the sufferer, because most societies however "primitive" have some form of medical practitioner with his own institutionalised role. Previously the personal problem was transmuted into a magical one, a problem of appeasing and controlling spiritual forces.

Now, although the magical element persists, it is largely changed into a technical problem without necessarily having any different effect on the patient's autonomy. If those who have never been exposed to Western culture are able to cope with pain and suffering with such competence, then it is surprising to find in pre-industrial societies such widespread use of opium derivatives and alcohol, and in South America the coca leaf.

Illich seems to consider these in some way different to pharmaceuticals, perhaps because they are derived from "natural" sources. Using this argument, one can justify the use of penicillin, cephalosporins, reserpine, digoxin, and tubocurarine, all of which were originally derived from plants or moulds. The production of alcohol is still a chemical process even in those societies where the reactions are not understood.

When Illich states that our society has become insensitive and has a higher threshold to the positive aspects of life because of our flight from pain and suffering, he does not take into account the widespread ingestion of drugs in non-industrialised society, nor the desensitising effect of repeated exposure to suffering, which in most cases produces a blunting rather than exaggeration of the response. If this argument were correct then those who had suffered most, for example in prison camps and natural disasters, should have the greatest capacity for positive experiences. All the evidence suggests that this is not so in fact they seem to be permanently affected in an adverse way (Mollen, 1964).

The pursuit of luxury and privilege seems to me a much more corrosive element, and once attained, frequently leads to a feeling that they are an inalienable right which should be kept, however much suffering they may cause to others.

If there is no hope of pain relief, then there are two alternatives, either to bear it or to commit suicide. If it is to be borne then the belief that it is all part of some cosmic plan may be helpful to the sufferer. Illich does not specify what intensity of pain or suffering we should be prepared to tolerate and, of course, ultimately given the availability of effective relief, the sufferer must himself decide at what level and after what duration his suffering becomes worthy of treatment.

Self-care by patients

Most people already understand that not every cold, headache, sprained ankle and temporary depression requires professional attention—these conditions have already been partially deprofessionalised by patients, as is shown by the expenditure in the United States of America of three billion dollars a year on non-prescribed medicines, about 40 per cent of the total expenditure on pharmaceuticals (Doll, 1973). Of course, many of these self-administered medicines are of no help and may even be harmful on occasions, so that one of our tasks should be to ‘professionalise’ some of this care and make the public more critical of advertising pressures.

There is still a large volume of mainly self-limiting diseases which could be handled by patients themselves or their relatives, but the reason for the lack of any organised attempt to propagate this idea is not just because of physicians’ reluctance to abandon their territory, but also because of the great difficulties in establishing criteria which could be used by the public as an easily comprehensible basis for their decisions.

In Britain, attendance at the doctor’s surgery for minor ailments is exaggerated by the need for certification in order to receive sick benefits, and optional self-certification for the first 7–14 days might cut down the number of unnecessary consultations.

Squandering resources

Illich’s criticisms carry particular weight when he discusses the resources squandered in developing countries on modern medicine. It seems likely that many of these nations, having disease patterns rather similar in many cases to Europe in the last century, might respond better to nutritional and sanitary improvements, rather than the use of expensive therapeutic measures.

All too often the medical profession in these countries has been a major force opposing improvements in health care. Usually they are trained in a totally inapposite way for dealing with local conditions and committed to practise in urban “centres of excellence”. Sometimes they are recipients of postgraduate education in Europe or the USA, which serves only to attract private practice from the small but powerful upper and middle classes, and reinforces a curative rather than a preventive attitude.

Preventive medical care versus curative medical care

Cure is more dramatic than prevention because prevention so often involves the community actively and is therefore more intelligible to it, whereas cure appears a more mysterious process and thus reflects more on the power and status of the healer. It is natural then that most people who become medical workers are attracted to the former at the expense of the latter, especially when they come from a different caste, clan or tribe from those whom they serve. However, it is significant that even those countries which began their health services emphasising preventive measures and use of local resources are now moving into high technology medicine. This trend is in fact desirable if it occurs after the preventive groundwork has been thoroughly laid and curable disease falls to levels which can be attacked by therapeutic methods within the available budget.

In many developing countries, however, the pressure of international pharmaceutical companies, with their sophisticated marketing techniques, can serve only to divert money from preventive to curative measures before this critical point is reached. It may also be extremely difficult for even progressive governments to resist pressures from a small but powerful educated class who feel that at least some high quality treatment services should be available in the country for them and their dependents. To ignore their opinion entirely may risk jeopardising other fundamental political and social advances, because in many countries with a large peasant population, these depend for their implementation on the support of this minority.

The USA with high *per capita* expenditure on health and poor national standards compared with many other Western countries (Doll, 1973), and a high volume of litigation against doctors (*The Lancet*, 1974) is particularly criticised by Illich, and is likely to be a result of making profits the paramount aim of the health care system.

It seems unlikely that scientific medicine would have spread to societies of such different political and cultural structures if it were based principally on the neurotic need to escape coming to terms with the necessity for suffering and death. Most people can come to terms with their own finite existence, and recently a more open attitude in discussing death with patients has been welcomed by many who find it more reassuring than attempting to maintain an attitude of denial (Hinton, 1974).

Despite the comparatively recent evolution of the idea that death normally comes in old age, it is an ideal which most would wish for and can view with some equanimity. Many people would prefer to die at home, and with the increasing openness about death this may become the norm in those with predictable incurable conditions.

Autonomy for the patient

Illich is certainly correct in demanding that individuals be given much greater responsibility in the management of their own condition, but this responsibility does imply greater comprehension. This does already occur; for instance, in the well-run diabetic clinic where many insulin-dependent diabetics are able to adjust dosage to suit changing conditions. Generally however the training of patients to understand and modify their bodily functions has been ill-explored, both because of doctors' reluctance to let patients into their province, and because it is often easier to take pills than to modify some established aspect of behaviour. Some of the recent work on voluntary control of autonomic responses using biofeedback and relaxation techniques has shown some promise in conditions as diverse as tension headache (Dudzuwski *et al.*, 1970), hypertension and cardiac dysrhythmias. There is an increasing number of conditions in which there appears to be a dietary component, and here the patient or relatives are almost entirely responsible for their own day-to-day management. Evidence is accumulating that dietary factors may have a decisive part to play in the cause of carcinoma of the bowel (Drasar and Hill, 1972) and possibly even of breast cancer. Undoubtedly in the future more relationships of this type will be discovered and many new possibilities of disease prevention on an individual and community basis will be realised.

From epidemiological studies it seems likely that many diseases common in our society are due to avoidable factors in our way of life that can ultimately be defined and acted upon, either on a personal level or as a matter of national policy, and it is this goal, rather than limitless use of pharmaceuticals, however useful they may be now, which is the most appropriate goal for modern medicine. It may eventually be possible to reserve therapeutics for those diseases due to spontaneous unpredictable mutations, those conditions with a strong genetic component which cannot be detected in utero and terminated, and perhaps for those people who are unable to change their life style to prevent disease. In addition, it is unlikely that levels of trauma would be reduced to levels not requiring the provision of treatment services, even if most other surgical conditions could eventually be prevented or treated medically.

Care of the elderly

In view of the increasing proportion of elderly people in our society, the ability of state institutions to cope with those who cannot live independently and whose relatives are unable or unwilling to look after them may soon be exceeded. It will then become necessary for the community to assume a more direct responsibility for the care of the elderly, just as, at the moment, we are all responsible for paying taxes to maintain

public services. In many areas the establishment of play groups for pre-school children is a prototype of the sort of organisation that might be required.

Many non-pharmacological ways of treating or preventing disease have demanded some sacrifice or unpleasantness from the patient in return for the therapeutic gain. We have, it seems, refrained from exploring the possibility that the whole process could be intrinsically enjoyable. When confronted with the possibility that physical training might improve exercise tolerance in angina patients, or reduce pressures in borderline hypertensives (Choquette and Ferguson, 1973) the first impulse is probably to envisage a programme of tedious exercises conducted in some dreary gymnasium rather than, say, organising dancing classes. Similarly, the common problems of mild anxiety or depressive states are usually treated empirically with drugs without even considering those social mechanisms by which they might be alleviated (Brown *et al.*, 1975). The resources within society for dealing with some health problems may well be enormous; they are certainly relatively unexplored, and it is possible that it may be partly a matter of directing people to suitable activities which are already available, but for reasons of sloth, imagined inadequacy, or reticence they have never attempted.

Assessment of Illich's contribution

Illich is a stimulating and original critic who represents an anti-scientific lobby whose numbers will increase parallel with economic and social turmoil. His mistrust is to some extent understandable, because all too often scientists have been uncritical about priorities and have rarely argued for the cessation of work in some developments whose products would be harmful to society. The faults of an industrialised civilisation, however, will not be solved by a panic reversion to pre-industrial techniques, which would be more likely to lead to a return to a feudal system rather than a more equitable distribution of wealth and power.

The importance of Illich's views lies in the fact that he has criticised medicine from the outside, thus raising points which might otherwise have remained unconsidered by the doctor with his superstructure of value judgments about his work. Illich has suggested that we can learn at least as much as we can teach to many non-technological cultures, and he has advocated greater involvement of the patient in his own therapy with both of which many doctors would agree.

It would be a pity, however, if his arguments were accepted uncritically by health planners and public opinion, already on the look-out for ways to reduce expenditure. Although ultimately it should be possible to make the National Health Service more cost effective, to cut ruthlessly now, at a time when the pace of advance is relatively rapid, is likely in the long run to delay the implementation of many new concepts, especially in prevention, which may be expensive to develop, but relatively cheap to maintain.

In spite of the extensive use of references Illich's hypothesis is at many points patently illogical, which may account for its considerable impact. A flight into irrational belief and behaviour commonly occurs at times of particular social and economic upheaval. In medieval times it frequently took the form of millenarism (Cohn, 1972). In our time it is likely to appear as a romanticisation of primitive or pre-industrial life styles, which may indeed have many admirable features, but which are not relevant to our predicament.

What is needed is greater democracy in the health services and sciences generally; not only must all involved workers be acknowledged as part of the team, but also the lay public must have a voice in the deployment of resources, and the broad direction of future advances. This may be organised partially by using those democratically elected bodies already existing in our societies, such as trade unions and local councils, but should also contain effective representation for the underprivileged.

Greater responsibility does, of course, require greater comprehension, but this would surely not be an insuperable task if television, radio, and newspapers fulfilled more of an educational role in society. If this does not occur, then during the forthcoming financial crisis the cutting of health budgets will fall mainly on the less articulate section of the community thus accentuating even further the inverse care law (Tudor Hart, 1971).

Clearly it is not Illich's intent to encourage the accentuation of inequalities in our society, but it could be his principal effect.

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'TOKENISM' IN MEDICAL SCHOOLS

“ Medical schools and faculties are becoming more conscious of the importance of family medicine and increasingly sensitive to government and consumer pressure to produce more family physicians. There is, however, a significant amount of ‘ tokenism ’ being practised. The small family practice unit tucked away in a corner with minimal funding and no status says little for the school in which it is situated. Even in the more enlightened schools there is competition for funds, facilities, and manpower with suspicion on the part of specialists towards family physicians and some paranoia on the part of family physicians towards their specialist colleagues.

It is essential that medical schools and their faculties become committed to developing and encouraging progressive family medicine departments, recognising that family physicians are best qualified to run these departments and that, in order to do an adequate job, adequate funds and facilities must be provided . . . ”.

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