McKeown's *The Role of Medicine:* Advancing Backwards

JULIAN TUDOR HART

General Practitioner, Glyncorrwg Health Centre, Wales

Professor McKeown has written a lucid and elegant book, which will add to his already great reputation. Despite his subtitle, he concludes that medicine is neither dream, mirage, nor nemesis, but must accept a relatively modest role, "to assist us to come safely into the world and confortably out of it, and during life to protect the well and care for the sick and disabled" (p. 173), acknowledging that other aspects of the social environment are and will remain the main determinants of health and mortality. This seems to me a very unremarkable conclusion, and the importance of the book lies elsewhere: in the arguments used to reach it, and their relevance to a mood of general retreat from the bolder objectives of the postwar social expansion throughout the Western world.

"Medical science and services are misdirected," says Professor McKeown, "and society's investment in health is not well used, because they rest on an erroneous assumption about the basis of human health. It is assumed that the body can be regarded as a machine whose protection from disease . . . depends primarily on internal intervention. The approach has led to indifference to the external influences and personal behaviour which are the predominant determinants of health. It has also resulted in the relative neglect of the majority of sick people who provide no scope for the internal measures which are at the centre of medical interest" (p. xiv).

The idea is not new. Again and again (if this book has one stylistic fault, it is repetition) it is assumed that both doctors and society in general have actually held the beliefs attributed to them, without significant dissent. "Treatment by surgery and drugs," says Professor McKeown, "is widely regarded as the basis of health. . . ." How widely? People who sell things have to believe in them, or face

the commercial consequences of honesty. Nowhere in his book does Professor McKeown note the fact that, in Britain at least, we stopped selling medical care as a commodity in 1948, and, despite an exasperating inertia in discarding useless skills, this has encouraged a healthy scepticism that pervades postwar entrants to the profession, even reaching the dominant group of teaching hospital consultants. The situation may be different in America, where the medical trade still flourishes in uneasy association with medical science, but how many practicing doctors really believe in the breathless image of "Medicine" projected by the *Reader's Digest* and trash television? Certainly there are many who do believe; there are always some people who will believe anything—even that coronary bypass surgery can reduce the number of premature deaths from ischaemic heart disease—but Professor McKeown has not convinced me that a majority of doctors are so much less intelligent than the general public.

This public does not consist of the owners and editors of newspapers, or of lay members of hospital boards. For generations, the people have known that good food, housing, education, and working hours and conditions were more important to their health than anything they could get from doctors. Yet when they asked, through political and trades union organisation, for the wages, hours, and social spending that alone could bring better health, they had to fight every inch of the way. Was it the fault of the people that society built infirmaries for patching up the poor, or at least which gave the appearance of patching them up, rather than face the social consequences of gearing production to the satisfaction of human needs instead of the generation of profit? Did they ask for doctors and hospitals rather than food, homes, and education? The positive elements in McKeown's thesis are commonplace to anyone with the least experience of the British or American labour movements. How should we view those whose conversion to these beliefs leads not to active support at the present time (for "we" can never presently afford to build homes rather than office blocks, or produce for those who have nothing rather than for those who have everything), not to help for those struggling for continued progress (whether or not this is profitable), but to denial—for the most sophisticated reasons, of course—even of something we have already won: a continuously improving access to an improving quality of personal care, however marginal this may be in its overall effect on mortality.

This case is not overstated. There is one set of statistics that Professor McKeown has not used, proving the positive side of his case in terms that defy all sophistry; the charge was perhaps too powerful for the slender missile he chose to fire. Figures are available for age-standardised mortality by social class for men in England and Wales aged 15 to 64. The mortality of unskilled labourers exceeded that of the professional and executive class by 23 percent in 1930-1932, 37 percent in 1949-1953, 88 percent in 1959-1963, and 78 percent in 1970-1972. Figures for morbidity (limiting long-standing illness found in random samples of the population) are available for 1972. The morbidity of unskilled labourers exceeded that of the professional and executive class by 156 percent in men of all ages, 99 percent in men aged 15 to 44, 202 percent in wives of all ages, and 93 percent in wives aged 15 to 44 (Hart, 1976). Clearly the expected improvement in health by feeding, housing, and educating the children of unskilled laborers as we do those of doctors and businessmen far exceeds the claims of even the most enthusiastic medical interventionists.

We progressive doctors, who have in the past allied ourselves with popular demands for the means to a better life, including improved access to better medical care, have always known that episodic symptom-response, or even the more or less continuous surveillance of anticipatory care, cannot be more than a small part of the conservation of health. Yet however small in the whole scheme of things, it was a very large part of our work and responsibility; we thought the element of reality in medicine was growing at the expense of illusion, that our specially informed and experienced hatred of disease could, despite all difficulties, be used as a base for genuine health care on a community basis. I don't think Professor McKeown helps us to do this. He has almost nothing to say about how our existing personnel and institutions might be turned at last to the unification of education, prevention, and treatment in our work as we actually do it, not as it may be speculated upon by committees devoted to the discovery of new names for old imbecilities. He strips out old faiths and puts little substance in their place.

A continued belief in medical science and in the responsibilities of doctors in helping with their own skills to build a better society must rest on a paradox ignored by McKeown, Cochrane, Burnet, Illich, and the entire company of Left, Right, or "value-free" critics of medical science. If the contribution of medical care to the conser-

vation of health is marginal, is this margin not greater now than ever before? If a large part of medical practice is illusory, is this component not smaller now than it was? Is not medical trade, and its consequent mystification of the people and self-deception of the doctors, diminishing, more and more isolated and discredited? Is medical science not growing, escaping from its primitive, mechanistic beginnings, and advancing to embrace the whole situations of health in society? If epidemiology does not have the place it deserves in teaching and research, is it not possible that its arid unattractiveness owes much to the failure of most of its leading exponents to use their skills positively? It is too nearly the case that they discover what is false in medicine, but not what is true. The truths found by courageous application of the numerator-denominator principle imply a need for positive change that cannot be contained within scholarly limits. They forever tell us what we should not be doing; but what should we do?

Why is it only now, when all over the Western world governments are retreating from the consequences of the liberal commitment to all social services—medical care, education, housing, all the determinants of health—why is it only now that we see such a flowering of critical philosophies, debunking medical science as irrelevant technology and denouncing the doctors as an exploiting class, or, more soberly, as with Professor McKeown, stripping the medical task to an extent that the most ruthless rationaliser of services, closer of hospitals, or applier of cash limits, would find it hard to match? Parenthetically, McKeown has many useful and original things to say, though few are developed positively. Occasionally the argument is uncharacteristically careless; there is ample evidence to refute his assertion that "most people end their lives without a period of incapacity" (Cartwright and Hockey, 1973), and is it really more useful to regard smoking as personal rather than social behaviour, collectively determined and mainly requiring collective solutions? But these assets or debits are irrelevant to the main message of the book, as it will be read, reported, reputed, and finally filter down to form the "received wisdom." The questions it raises, and the answers it gives, are not new; but the context certainly is, and it is a context of which none of us can claim ignorance.

Not only philistine businessmen but liberal scholars have rediscovered that the rich must have more wealth if any of it is eventually to reach the poor, that our economies are failing because wages are too high and profits too low, and everyone is being weighed down

by an excess of medical care, education, and other subjects peripheral to the main task of society, namely to produce anything that can be sold in the largest possible quantity. In this situation, "progressive" demands for retreat to pastoral solutions have become a form of reactionary opinion acceptable to a large part of the inexperienced New Left, with predictably divisive effects on what might otherwise have been a much broader and more united front against the present cuts in the Health Service.

The obstacles both to the balanced development of medical science, and to its application, are those of social organisation: the episodic nature of care, lack of continuity, poor communication, and indirect or distorted motivation—a general failure to create the conditions required for safe and effective experimental medicine at a personal or population level. Contemporary medicine is by its nature either experimental, fraudulent, or a mixture of the two; it is a very big demand, to require such conditions, but there is no other way in which medical science (not a pretence of science) can be delivered. Social obstacles appear to an established ruling class as unchangeable, since they imply changes in organisation that would demote their own position; they are always the last to perceive their own redundancy, convinced that society rests upon them, not the other way round. The medical profession has in the past succeeded in negotiating a special relationship with this ruling class, which not only advanced its own status, but ensured patronage of a kind for medical science. This relationship may now be coming to an end. Medical science, with the whole scientific community, is increasingly on offer to the mob as scapegoat for a form of social organisation whose real fault lies in the philistine equation of private greed with public good.

I do not believe this offer will long be tolerated by scientists, or accepted by the people—not a mob, but people increasingly conscious of their own value and power, with a more sober expectation of the capacities of medicine than we have credited. They continue to believe that medical science is a necessary part of a better future. This offers us the opportunity for a new and more fruitful social alliance, which will in turn redefine the medical role in more popular terms. More popular, but no less scientific; science must escape from its imprisonment in the teaching hospital and the laboratory, become the posession not only of every medical worker, but of patients also, and resume that exponential growth that has been no illusion, but the most hopeful fact of the twentieth century.

References

Cartwright, A., Hockey, L. 1973. *Life before death.* London: Routledge & Kegan Paul.

Hart, J.T. 1976. General practice workload, needs and resources in the National Health Service. *Journal of the Royal College of General Practitioners* 26: 885-892.

Address reprint requests to: Julian Tudor Hart, MB, DCH, MRCGP, Glyncorrwg Health Centre, near Port Talbot, Glamorgan, Wales, SA13 3BL