the tyranny of health

doctors and the regulation of lifestyle

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'A spirited and far-reaching enquiry into medicine's current discontents' James Le Fanu
wider context. The overall rate of infant deaths in 1990 was slightly less than 8, by 1996 it had fallen below 6. At the turn of the century the figure was around 150, by the Second World War it was still above 50; it did not fall below 20 until the 1960s (Halsey 1988) In some Third World countries today, the infant mortality rate remains comparable with that of Britain in the early decades of this century: for example, India—94, Bangladesh—114, Egypt—61, Mali—164 (Gray 1993:11). Infant mortality has fallen dramatically among all social classes in Britain in the course of the twentieth century. In 1922 infant mortality among unskilled workers was 97; for the children of professionals, the rate was 38 (Halsey 1988). Over the past 70 years, the rate has fallen to roughly the same extent—between 80 and 90 per cent—among both the rich and the poorest. The infant mortality rate among the poorest families today is similar to that of the richest in the 1970s.

As new public health statisticians are well aware, it is possible, by carefully choosing one’s starting point and other manoeuvres, to reveal slight increases or decreases in class differentials in infant mortality. But what all such comparisons of mortality rates obscure is the dramatic decline in the absolute number of infant deaths. In 1990 the total number of babies dying in the first year of life in England and Wales was 3,390; in 1900 the figure was 142,912, in 1940 it was still higher by a factor of ten and in 1970 more than four times greater (OPCS 1990; Halsey 1988). The 1990 figure included 248 deaths among babies of parents in social class I and 243 in social class V (though the total number of babies born in this category was half that of class I). Though infant deaths may be relatively more common in poorer families, they are very uncommon in any section of society. A commonplace event within living memory in Britain, the death of an infant has now become a rarity. Furthermore many of these deaths result from conditions such as prematurity and congenital abnormalities, which are often difficult to prevent or treat, or are ‘cot deaths’, the causes of which are uncertain and preventive measures remain controversial. Again, it seems that the level of government and official medical intervention is out of all proportion to the scale of the problem.

The more closely you examine the new public health the more strange its focus on problems of vanishing significance appears. Yet, despite the limited scope for preventing disease by changing lifestyle, campaigns endorsed by the government and the medical profession to alter individual behaviour have had a major impact on society over the past decade. Nobody capable of watching television
the dangers of passive smoking, setting a bad example to others—particularly by parents to their children. The authoritarian dynamic in New Labour’s public health policy becomes increasingly apparent as we move from the discussion of aims and targets to the local ‘healthy settings’ in which the policy will be implemented and contract compliance enforced. ‘The contract will only work if everybody plays their part and everyone is committed to fulfilling their responsibilities’ declares the Green Paper in a tone reminiscent of a headteacher’s lecture, a managerial pep talk or a vicar’s sermon (DoH February 1998:29). In ‘healthy schools’, children will have their eating habits monitored to promote ‘healthy eating’ and be dragooned into physical exercise. Meanwhile in their ‘healthy workplaces’ their parents will be following the government’s list of precise instructions for ‘employees’. They are all to follow a healthy and safety guidelines’, ‘work with employers to create a healthy working environment’, ‘support colleagues who have problems or are disabled’ and ‘contribute to charitable and social work through work-based voluntary organisations’ (DoH February 1998:51).

In my surgery I see two striking consequences of the ascendancy of the new public health. On the one hand, I meet the burgeoning numbers of the ‘worried well’, young people who would once have been considered healthy, but are now—with official encouragement—anxiously seeking ‘check-ups’ and advice about an ever widening range of diseases about which there is an ever increasing level of awareness. The facts that many of these diseases are rare, that screening tests are often not helpful and that preventive measures seldom have proven value makes no difference to the demand for advice, assessment or reassurance. On the other hand, I meet many older people with serious health problems caused by osteoarthritis of the hip, cataracts or coronary heart disease who are suffering (and sometimes dying) waiting months and years for surgical treatments. While resources are poured into projects that use health to enhance social control, real health needs—especially those of the elderly—are neglected.

In the following chapters we will be looking more closely at different aspects of the medicalisation of society, including both the widening range of medical intervention and at its greater penetration into the personal life of the individual. This is a process with adverse consequences for the individual and for society. Despite the fact that more people enjoy better health, the intense awareness of health risks means that people feel more ill. This results in an increasing
negligible sexual experience, he was worried he had developed Kaposi’s sarcoma, a once-rare skin cancer that now appears in some people with Aids. He reckoned that the red patch on his chest looked exactly like the one exhibited in the cause of public health promotion, by an Aids patient on television. In fact, he had ringworm. I remember too a man in late middle age who was terrified that he might have acquired HIV in the course of a single homosexual experience while in the services during the Second World War. The ‘worried well’ became a recognised disease category, their anxieties accepted as a price worth paying for heightened Aids awareness.

The Aids panic provided the model for numerous subsequent scares, none reaching the same dimensions, but several having a substantial and enduring impact. Many more minor scares came and went, cumulatively fostering a climate of increasing public anxiety about threats to health that was receptive to a growing scale of state and medical intervention in the personal life of the individual. Alarmed by these scares, people consulted their doctors, not so much because their concern about some particular symptom, but because of their re-interpretation of the significance of this symptom in the light of their new awareness of some wider threat to health. There was (almost) always a rational element in their concern: there was a real threat to health (to some people) at the root of most of the major scares and many of the minor ones. The dominant—irrational—element was expressed in a level of concern that was out of all proportion to the real danger. Let’s look at some of the major and minor health scares of the past decade.

**Major health scares**

**HIV|Aids**

In November 1986 the British government launched the ‘biggest public health campaign in history’ about the threat of the Acquired Immune Deficiency Syndrome (Aids) resulting from the Human Immunodeficiency Virus (HIV). Advertisements ominously featuring ‘tombstones’ and ‘icebergs’ appeared on television, in cinemas, on high street hoardings and in the press; the ‘Don’t Die of Ignorance’ household leaflet followed in early 1987. The central theme of this campaign was the risk of a major epidemic of HIV disease in Britain resulting from heterosexual transmission. The
character. The risk to any particular individual of acquiring this disease may be low, but it is often also either indeterminate or difficult to establish with any accuracy, creating great scope for speculations which invariably feature worst-case scenarios. Though there have been scares in the past, the recent wave is unique in its scope and impact. Let’s take these points in turn.

The diseases at the root of the major scares are generally terrifying and often rapidly fatal. Some are grossly debilitating (Aids, nvCJD), others disfiguring (malignant melanoma). Some cause sudden death in previously healthy individuals (cot death in babies, pulmonary embolism in women on the Pill), others cause lifelong disability (autism). All these conditions are difficult, if not impossible, to treat. They often appear to strike the most innocent, or even if that is not generally the case, as with Aids, ‘innocent victims’—babies infected by their mothers, or recipients of infected blood transfusions—are singled out for particular sympathy. Health scares are all the more frightening when they are associated with some intimate or familiar activity, like sex, eating, sunbathing, putting the baby to bed. The apparently random way in which these demons strike, reinforced by the vogue for quoting risks like gambling odds, encourages gloomy forebodings and reinforces a fatalistic outlook.

Health ministers and medical authorities have been criticised for their failings in communicating the subtleties of risk to the public—and thereby inflaming public fears, particularly in relation to mad cow disease and the Pill. No doubt there are real problems here. In the case of the Pill, the risks are so low that they are difficult to measure and, once measured in large population surveys, it is difficult to distinguish between an increase that is statistically significant and one that is significant in terms of clinical practice. In some cases, for example that of the risk of acquiring nvCJD from eating beef, or that of a child becoming autistic as a result of the MMR vaccine, the risk is impossible to quantify (it may well be non-existent). This has led to the absurd demand from campaigners for proof that there is no risk from beef or the MMR vaccine before they can consider it safe for people to be exposed to these potential sources of disease. The very indeterminacy of the risks involved in most health scares allows those who are so inclined to speculate wildly, thus inflating anxieties further and justifying further official intervention.

In the not so distant past the common focus of health scares was the threat of outbreaks of infectious epidemics, which produced
them to a public with an apparently insatiable appetite for such stories. Once in the public domain, the scares developed a life of their own, often producing effects far greater than were either expected or desired by their originators, a trend best exemplified by the mad cow panic of 1996.

3 Backlash

At a certain stage, every health scare provokes a critical response towards which there are a number of contributory factors. The backlash usually starts from representatives of a body of medical or scientific opinion which is sceptical of the basis on which the scare has been launched. The challenge to the role of HIV as a cause from the retrovirologist Peter Duesberg and others, together with criticisms of the official line of exaggerating the risk to heterosexuals, provoked some wider questioning of the Aids panic in the early 1990s. In relation to cot death and malignant melanoma, we have already quoted dissident paediatricians and dermatologists. The scares about the Pill and the MMR vaccine were unusual in that most experts in both fields were bemused by the scares from the outset. In the case of the Pill, most family planning authorities did not believe that the reports of increased risk were clinically significant, and in the case of the MMR vaccine, neither gastroenterologists nor child psychiatrists were, in general, much impressed by the evidence adduced by Wakefield and his colleagues. Doubts about the BSE-nvCJD link were even more profound, as the prion theory on which the whole concept of ‘transmissible spongiform encephalopathies’ is based remains controversial, and various alternative hypotheses concerning the aetiology of these conditions are in circulation.

The media, always alert to a new angle, and particularly keen on controversy, soon pick up the views of critical experts and provide them with a platform from which to expound their views. To some extent the resulting debate helps to keep the panic alive when the public may be beginning to tire of the same old scare story. However, at the same time, it begins to cause some irritation as people become confused by rival arguments, often of an increasingly esoteric character. The popular view that ‘if the experts can’t agree about these problems, how are we supposed to make up our minds?’ adds cynicism to anxiety.
power, Mrs Thatcher could be put on the defensive over health, an issue that had been regarded as the property of the Labour Party since the establishment of the post-war welfare state. Ten years later, Mrs Thatcher’s successor, John Major, presided over the launch of *The Health of the Nation*, the most extensive programme of state intervention in personal ‘health-related’ behaviour ever introduced by any British government—before the public health policies of New Labour after 1997. One of the main forces driving this dramatically rising profile of government intervention in personal health over this period was the parallel decline in the prestige of government. This problem became particularly apparent for Mrs Thatcher in her third term after 1987, when her earlier successes over the unions could no longer compensate for the widespread rejection of policy that was exposed when the illusion of ‘popular capitalism’ built on the speculative Thatcher/Lawson boom of the late 1980s was exposed in a new recession. Raising awareness about Aids to preventing heart disease, and cancer, campaigning to improve the nation’s health offered the government a new vehicle for recovering popular support.

The government also recognised that it was not the only public institution that had suffered a loss of esteem in the eyes of the nation. It was concerned about the decline in influence of traditional sources of authority, such as the mainstream churches, even political parties and trade unions, and the resulting loss of cohesion in society, a trend exacerbated by the increasing economic and social instability of the 1980s. The ready audience for health scares indicated the extent of the process of fragmentation; it also suggested that health might provide a means of official intervention, seeking both to replace defunct mechanisms of regulating personal behaviour and to provide new modes of solidarity.

The Aids panic marked a decisive shift in government policy towards direct intervention in intimate personal behaviour. This shift was all the more significant in that it took place under Mrs Thatcher, who was well-known for her hostility towards state intervention and for her distaste for public discussions about sex. However, though Mrs Thatcher distanced herself personally from the Aids campaign—conspicuously vetoing government support for a proposed national study of sexual habits—she nevertheless made sure that from the outset the campaign was supervised by a top level Cabinet committee. In fact, the Aids campaign was quite compatible with the moralising themes that ran through the Conservative governments of the 1980s and 1990s, from Mrs Thatcher’s ‘Victorian values’ to Mr
Major’s ‘back to basics’. Indeed, because it was more subtle than these campaigns, and organised around an issue of health, the Aids scare proved a vastly more successful moral crusade than these more traditional initiatives.

The key to the success of the moral dimension of the Aids panic was the early shift away from an old-time-religion, explicitly anti-gay, pro-family, approach, which was favoured by some influential clerics, police chiefs and Tory politicians. This outlook, associated with the religious right, remained a persistent, but marginal influence on Aids policy in Britain (though it was more powerful in the USA). By the time the government launched the major Aids campaign in Britain, the distinguishing feature of its morality was its denial of having a moral line. Instead it proclaimed an explicitly non-judgemental, tolerant and pluralistic outlook. The campaign implicitly accepted homosexuality ‘gay or straight’ as the government’s propaganda on ‘safe sex’, implying a moral equivalence that was anathema to the Christian right. It also accepted sex outside marriage, a complete, unprecedented public gesture for a Conservative government. In the early stages of the Aids campaign, journalists were bemused to discover that cabinet ministers and senior civil servants were discussing the relative risks of vaginal and anal intercourse, the virtues of oral sex and the delights of condoms; within months these topics had moved to the mainstream media and before long were on the national curriculum.

While radicals and gay activists applauded the government for its boldness in promoting open discussion about matters of sex and urged it to go further, they ignored the fact that the ‘safe sex’ code promoted by the Aids campaign simply replaced the traditional moral framework with a new one. It replaced the fear of eternal damnation, which no longer offered much of a deterrent to youthful sexual experimentation, with fear of a lethal disease, a much more potent force. The new moral code no longer exhorted people towards ‘goodness’, but replaced this with the ethic of ‘safety’, according to which all manner of sexual activity could be classified as ‘low’, ‘medium’ or ‘high risk’.

Instruction in the new moral framework was provided by an army of Aids activists, employed at every level in health, education, local government as well as through television programmes, posters, leaflets, pamphlets and books. ‘Not since the heyday of the Catholic convent school had children been so bluntly instructed in the causal link between sex and terror’, wrote Mark Lawson in a retrospective commentary on the Aids campaign in the Guardian in 1996 (Lawson
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THE REGULATION OF LIFESTYLE

Everybody should try to look after themselves better, by not smoking, taking more exercise, eating and drinking sensibly.


While clinical trials have shown the benefits of stopping cigarette smoking, many of the changes in lifestyle that are being promoted by Western governments are based on information lacking in solid evidence. It is unpardonable to try to alter the diet of an entire population without sufficient information.

(David Weatherall, Science and the Quiet Art, 1995:311)

Nor can very much be changed by the trendy fashions in changing ‘life-styles’, all the magazine articles to the contrary; dieting, jogging, and thinking different thoughts may make us feel better while we are in good health, but they will not change the incidence or outcome of most of our real calamities.


David Weatherall, currently director of the Institute of Molecular Medicine at Oxford, and formerly Nuffield professor of clinical medicine at Oxford, is one of Britain’s leading clinical scientists; Lewis Thomas, professor of paediatrics, pathology, medicine and biology and dean of two medical schools, enjoys a similar status in the USA. The discreet scepticism of these two eminent medical authorities regarding the central themes of government public health policy on both sides of the Atlantic indicates two things: that some medical experts question the scientific basis of this policy—and that this questioning has had done little to deter the rise of public health
to the list of conditions caused by ETS (California EPA 1997). British meta-analyses confirmed increased risks of lung cancer (24 per cent) and coronary heart disease (23 per cent) (Hackshaw et al. 1997, Law et al. 1997). A re-analysis of the same studies three years later acknowledged a ‘modest degree of publication bias’ (a result of the fact that studies which reveal no increased risk are less likely to be published) and adjusted the excess risk of lung cancer down from 24 per cent to 15 per cent (Copas, Shi 2000).

The case against ETS transformed smoking from a self-endangering choice into an anti-social act. The smoker was not only engaging in a personally destructive practice, but one which was polluting the immediate environment and threatening a cast of ‘innocent victims’—non-smoking spouses (generally wives), children, unborn babies. Parental smoking could be regarded as little better than child abuse (indeed it soon became a significant barrier to adoption). The campaign led to the establishment of ‘smoke-free’ areas and then smoking bans in workplaces, on public transport and other public spaces. The award of £15,000 in damages to Veronica Bland, who claimed that her chronic bronchitis resulted from eleven years of exposure to smoking workmates, marked the public affirmation of the status of the passive smoker in Britain. As the medical historian Allan Brandt observed, ‘in less than a decade, American public space was radically subdivided on the basis of the harms of passive smoking’ (Brandt 1998).

Despite the growing medical (and political) consensus about the dangers of passive smoking, the issue has remained controversial. The Swedish toxicologist Robert Nilsson, while accepting the plausibility of the ETS-lung cancer link and the fact that numerous studies appear to show a statistically significant increase in risk, has questioned its epidemiological significance (Nilsson 1997). Thus he offered estimates, on the basis of current knowledge, of the annual incidence of cancer in a population of 100,000 resulting from various environmental factors: unknown (177), diet (135), smoking (68), other lifestyle factors (45), sunshine (23), …ETS (2). By contrast, in a population which consumes Japanese seafood (which contains arsenic) this will cause 12 cases of cancer; where there are traces of natural arsenic in drinking water, this will cause five cases; eating mushrooms will cause three cases. In other words, the risk of ETS is comparable with that of environmental agents which are generally regarded as an insignificant threat to health.
or reverse these pathological processes and reduce the rates of resulting death and disease has subsequently become the conventional wisdom of Western society. The popular description of the traditional British fried breakfast as a ‘heart attack on a plate’ reflects the familiarity of the diet-heart disease thesis.

It is indeed a plausible theory, yet, despite decades of intensive study, it still lacks scientific verification. Through the 1960s and 1970s controversy raged over the significance of dietary fat and the association between cholesterol and CHD and numerous researchers studied different aspects of the alleged link. A major joint US/European study—the Multiple Risk Factor Intervention Trial (MR FIT)—investigated the effect of various diets and lifestyle changes on 60,000 men. Other investigators identified additional risk factors for coronary heart disease, notably smoking, lack of exercise, raised blood pressure, and many more.

At the end of 1982, according to James LeFanu, a long-standing critic of the cholesterol-heart disease thesis, ‘the juggernaut crashed’ (LeFanu 1999:335). The MR FIT trial could no benefit from intervention (and a WHO study a few months later came to the same conclusion). Furthermore, figures showed that the incidence of CHD was falling in different countries, in all ages, classes and ethnic minorities—apparently independently of dietary changes. Yet far from bringing to an end attempts to change diet justified by the cholesterol-heart disease thesis, campaigns promoting ‘healthy eating’ won ever greater official backing and became steadily more influential. This is the remarkable paradox underlying health promotion in relation to CHD, to which we will return in the next chapter. Here, we simply note the fundamental improbability of the diet-CHD thesis: human beings have lived throughout history, and continue to live, in the most diverse habitats on the most diverse diets, displaying phenomenal adaptability. It would therefore seem ‘improbable that for some reason right at the end of the twentieth century subtle changes in the pattern of food consumption should cause lethal diseases’ (LeFanu 1999:319–20).

There can be no doubt however that, even though—in scientific terms—the cholesterol juggernaut had crashed, in the sphere of public health policy, it was surging ahead. In 1979 the British government published guidelines on *Eating for Health* which attempted to overcome the ‘ignorance and irresponsibility’ which it blamed for unhealthy lifestyle. The media responded to this initiative with ‘unbounded enthusiasm’, publicising the dangers of cholesterol to a receptive audience (Karpf 1988). The ‘Look After Yourself
cholesterol levels. More drastic diets, which are required to achieve the target cholesterol reduction (‘step 3’) are widely regarded as unpalatable and cannot be sustained by most people. These authors recommended that proponents of the cholesterol thesis ‘should apply the same rigour to assessing the effectiveness of intervention as they have to their analyses of the epidemiological and clinical trial data’.

Another limitation on the preventive value of dietary intervention is the fact that CHD is overwhelmingly a disease of the elderly —83 per cent of people who die from CHD are over 65. The significance of this may be clarified by calculating the increase in life expectancy resulting from a fall in CHD mortality of 25 per cent (the consequence of a 10 per cent reduction in blood cholesterol levels): between 2.5 and 5.0 months (Bonneux and Barendregt 1994). In response to this (and another computer modelled calculation which estimated the possibility of a median increase of 12 months), supporters of dietary intervention argued that the average increase over the whole population concealed the benefit to those who would otherwise die from CHD (for whom the increase was on average four years, and eight for those dying under fifty) (Law et al. 1994a). But this is a statistical sleight of hand: if dietary change is being recommended for everybody, then its benefit must be measured across the whole population. Faced with the choice between forgoing the pleasures of meat and cheese and prolonging a miserable fruit and fibre existence for a few more months, many people might opt to eat now and forfeit the few extra months.

The distinction between relative and absolute risk we considered in relation to passive smoking also applies to diet. It is important to distinguish between the apparently impressive improvement in the relative risk of CHD resulting from dietary change and the marginal improvement in absolute risk. Two American professors of medicine made this point in response to the ‘cholesterol papers’ debate in the BMJ in 1994:

Most doctors answer in the affirmative when asked whether they would take a daily pill to reduce their chances of dying from a heart attack by 50 per cent. When asked whether they would do so for ten to twenty years if the risk was reduced from 2/1000 to 1/1000, a reduction of 50 per cent, there is much less enthusiasm.

(Vine, Hastings 1994)
In 1971 Carol Downer stole a speculum from her doctor’s office in Los Angeles and, aided by a mirror and a flashlight, became possibly the first woman in history to see her own cervix. Within twelve months she was running a women’s self-help health group, turning to alternative medicine to treat vaginal discharge and using household remedies as well. The clinic was subsequently raided by the Los Angeles Police Department and she was charged with entering a vagina without a medical license. The LAPD attempted to seize as evidence a pot of yoghurt but were restrained by a woman who insisted it was her lunch. The incident quickly became known as the Great Yoghurt Bust and went on to make its appearance in court as the Great Yoghurt Trial. Downer was acquitted, thus establishing a precedent in California: women’s genitals were no longer territory reserved for men.

(Linda Grant, *Sexing the Millennium*, 1993 p. 179)

Perhaps the last word on the subject [of cervical smears] can be left to a consultant pathologist, A.R. Kittermaster, writing in *World Medicine*. He felt diffident, he explained, about giving advice on screening for a disease which, as a man, he could not contract. When he considered a roughly equivalent disease which he might get, such as cancer of the prostate, he would certainly be willing to have the equivalent test if he had suspicious symptoms; ‘but if anyone—and particularly a female—suggested that young men should start having regular smears to diagnose and treat pre-malignant lesions, twenty years before the average age for invasive cancer, I should be highly suspicious of the whole affair’. Certainly he would want proof that treatment in such circumstances had a dramatic effect on the death-rate; and if he knew (as he did for cervical lesions) that having a smear carried an unavoidable risk of an incorrect diagnosis, ‘then I would tell whoever was advocating the smear to go jump in the lake and poke their nose—or rather, their finger—somewhere else’.

(Brian Inglis, *The Diseases of Civilisation*, 1981 p. 69)
In 1995 the organisers published the results of the first five years of the mammography programme and claimed some credit for an 11 per cent drop in mortality from breast cancer in the target age group (Beral et al. 1995). In response, Professor Michael Baum, who had helped to set up the screening service, pointed out that though the mammography programme could not be expected to have an effect on mortality before 1997, the decline in the death rate began in 1985. Suggesting that a more likely explanation was the introduction of the drug Tamoxifen for the treatment of breast cancer, he argued that ‘to claim that any part of this 11 per cent fall is attributable to the screening programme is intellectually dishonest’ (Baum 1995). In protest, he resigned from the Department of Health’s breast cancer screening advisory group.

Baum also pointed to the high level of false positive results generated by mammography, causing anxiety and leading to further investigations, either aspirate cytology or excision biopsy. He concluded that mammography was ‘not worth doing’ because it saved too few lives at too high a cost, while causing needless anxiety among thousands of healthy women by incorrectly suggesting that they have the disease (Rogers 1995). He suggested that the money spent on screening might be better spent on research and specialist treatment for women diagnosed with breast cancer. But breast cancer screening had acquired high political prestige; only three months earlier a parliamentary select committee had commended the mammography programme as a model of excellence in preventive health care and had called for it to be extended to cover women up to the age of 69. Baum’s proposals were ignored.

The controversy over breast screening flared up again five years later. A study by a team from Denmark reviewed major trials of mammography in Sweden, Scotland, Canada and the USA, involving 500,000 women, and concluded that there was ‘no reliable evidence that screening decreases breast cancer mortality’ (Gotzsche, Olsen 2000). Prominent representatives of the government screening programme and the leading cancer charities immediately rejected this conclusion and asserted their conviction that mammography saved lives. Delyth Morgan, chief executive of Breakthrough Breast Cancer, insisted that ‘we must not be deterred from continuing our screening programmes until we have seen categorically that they are ineffective’ (Guardian, 7 January 2000). This ethical imperative to prove a negative stood in dramatic contrast to the one imposed twenty years earlier in what has become recognised as a classic paper (Cochrane, Holland 1971). These
foods’, ‘healthy eating’, ‘sexual health’, ‘exercise for health’. Whereas feminists once rejected ‘women’s health’ as a form of male medical domination, their latter-day sisters have embraced ‘lesbian health’ as an affirmation of identity; in a common spirit of victimhood we now also have ‘men’s health’. The cult of exercise, pursued not for the enjoyment of sporting activity as such, but in the cause of improving physical fitness in the abstract, reflects the ascendancy of preoccupations about health over personal behaviour.

The third theme is the transformation of the medical role and the emergence of new institutions that mediate between the individual and the state in the sphere of health. The change in the role of the doctor is most apparent in general practice, in many ways the frontline of the advance of medical intervention in lifestyle. In the not-so-distant past, general practice was a demand-led service: patients came to the surgery complaining of illness and doctors offered diagnosis and treatment; concern, within the limits of their own abilities and those imposed by medical science and health service resources. Over the past decade, general practice has shifted to a more pro-active approach, inviting patients to attend for health checks and screening procedures and adopting a more interventionist role in relation to lifestyle issues, such as smoking and drinking, diet and exercise. Instead of serving their patients’ needs, GPs now serve the demands of government policy—and the dictates of government-imposed health promotion performance targets. New procedures, such as the routine check-up and the lifestyle questionnaire, allowing the systematic recording (now in a readily accessible computerised form) of intimate knowledge of the patient, have become a familiar feature of the doctor-patient relationship.

Having taken on a major role in health promotion, the government has worked with the established organisations of the medical profession—the various royal colleges, the BMA and others—to push forward initiatives like the Health of the Nation campaigns of the early 1990s. It has also recognised the limitations of these traditionally conservative and inflexible bodies and has encouraged the development of a range of institutions to play a more dynamic role. An early example of this approach was the establishment of the Health Education Council in 1968; this was transformed into the Health Education Authority in the heat of the Aids crisis twenty years later and was finally wound up in 2000 as its functions were subsumed by New Labour’s Health Development Agency and other public health initiatives. The internal controversies
the appropriate medically-sanctioned standard of behaviour as a duty to society. The burden of personal responsibility is reinforced by elevation of risks to others that may arise from individual failings: hence the emphasis on ‘innocent victims’ of HIV/AIDS (children, haemophiliacs), the passive smoker, the foetus (of smoking, drinking, drug-taking mothers). Since traditional moral sanctions on behaviours considered deviant have become ineffective as a result of the declining power of the churches in society, values derived from health promotion have acquired growing influence. As the American historian Francis Fukuyama has noted, ‘we feel entitled to criticise another person’s smoking habits, but not his or her religious beliefs or moral behaviour’ (quoted in Thomas 1997). Indeed smokers have become pariahs in modern society—and those who deviate from other healthy lifestyle standards (such as the conspicuously obese) can also expect to meet with explicit social disapproval. In this way, the individual’s state of health is manifested in the state of their body—provides a public testimony to their conformity with the new moral code of healthy living, a code which is in many ways more authoritarian and intrusive than the religious framework it has replaced.

In expanding to fill the moral vacuum resulting from the decline of the churches and the increasing fragmentation of society, medicine has come to play a much wider social role. It has displayed considerable flexibility in incorporating both traditional concerns about the decline of family values and fashionable commitments to pluralism and diversity, particularly in the sphere of sexuality. The philosopher David Mechanic has observed how medicine ‘can be, at the same time, remarkably tolerant and extraordinarily judgemental’, now accepting, for example, masturbation and homosexuality, after a long history of pathologising these activities, but fiercely condemning any departure from the safe sex code (Mechanic 1997). As Mechanic continues, there are such large areas of uncertainty today that ‘moral entrepreneurs have endless opportunities to ply their trade’. Nowhere are these opportunities so great as they are in the sphere of health promotion.

It is important, however, not to exaggerate the potential of health to take over the role of religion. The parallels between Moses’ Ten Commandments and Liam Donaldson’s Ten Tips for Better Health are striking—they are even more explicit in the ‘European Code Against Cancer, or Ten Commandments’ cited in the Health of the...
1979, 1980). Federal health promotion connected with a growing interest in self-help and consumerism, and with the vogue for jogging, marathon running and other forms of physical fitness, which reached Britain a few years later.

Government health promotion initiatives in the 1970s provoked a vigorous radical response, particularly in the USA. In a classic paper which anticipated subsequent trends with uncanny accuracy, the American sociologist Irving Zola commented that medicine was ‘becoming a major institution of social control’ (Zola 1972). He discerned a tendency towards the ‘medicalising’ of much of daily living which was proceeding in ‘an insidious and often undramatic’ way. Furthermore he noted that ‘the list of daily activities to which health can be related is ever growing and with the current operating perspective of medicine it seems infinitely ‘expandable’. As this process gathered momentum, the tone of the critique sharpened. In the late 1970s, another American sociologist, Robert Crawford, characterised health promotion as ‘victim-blaming’, an ‘ideology which blames the individual for her or his illness and proposes that, instead of relying on costly and inefficient medical services, the individual should take more responsibility for her or his health. At-risk behaviour is seen as the problem and changing life-style, through education and/or economic sanctions, as the solution’ (Crawford 1977). In his view, these ‘ideological initiatives’ had two functions. On the one hand, they served to ‘reorder expectations and to justify the retrenchment from rights and entitlements for access to medical services’. On the other, they attempted ‘to divert attention from the social causation of disease in the commercial and industrial sectors’.

The Health of the Nation

It was not until after her third general election victory in 1987 that Margaret Thatcher seriously set about reforming the health service. The 1989 White Paper Working for Patients heralded the introduction of the internal market into the NHS, with hospital trusts and GP fundholding. Yet, by the time these measures became operational in 1991, Mrs Thatcher had been replaced by John Major, and it was under his leadership that the Health of the Nation policy was introduced, with a Green Paper in June 1991 and a White Paper in July 1992 (DoH 1991, DoH 1992). This comprehensive health promotion programme was ideally suited to Major’s attempt to
equality. In 1985 the European office of WHO adopted a set of 38 targets against which progress of different national governments towards the goals of ‘Health for All’ could be measured. The ‘new public health’ made further advances the following year, when a conference in Ottawa endorsed the movement’s emphasis on the ‘empowerment’ of communities to take the initiative in matters of health promotion away from governments and professionals. A further conference in Lisbon brought together new public health activists engaged in ‘healthy city’ projects organised by local councils, around the themes of ‘equity in health’, ‘community participation’, ‘partner-ships for health’ and ‘inter-sectoral collaboration’.

A number of critics have exposed the curious combination of utopian fantasy and cynical rhetoric that characterised the new public health movement. While activists projected a vision of revolutionary social transformation, it was only as employees of (decidedly moderate) government agencies that they had any prospect of implementing their health promotion policies. ‘To state the matter baldly’, as two disillusioned Canadian public health activists put it, ‘the movement for health promotion is not a social movement but a bureaucratic tendency; not a movement against the state, but one within it’ (Stevenson, Burke 1991). The Australian sociologist Deborah Lupton accurately identified a contradiction in the movement’s conception of ‘empowerment’: if someone who is more powerful ‘empowers’ someone who is less powerful, their relationship is still didactic and paternalistic (Lupton 1995:60). In a similar vein, Sarah Nettleton argued that the ‘fallacy of empowerment’ was revealed by the fact that health promotion was invariably oriented towards the least powerful people in society (Nettleton 1995:238). A number of commentators noted the origins of the ‘healthy cities’ projects in ‘paternalistic and cynical’ ‘community development’ programmes developed by the British colonial office in the 1950s to contain potential unrest, suggesting that establishment concern about preventing inner city revolt after a series of riots in the early 1980s provided the impetus behind community health initiatives (Farrant 1991; Peterson, Lupton 1996). Critics also focused on the potential for discrimination and containment that lay behind concepts of ‘community’. They observed that ‘participation’ often had a token character, which co-opted people into the existing power structure while giving them no real power in making decisions. Thus, while espousing a rhetoric of radical social change, in practice the activists of the new public
commitment of all relevant government departments to ‘inter-
sectoral collaboration’ in the cause of health, the White Paper was
signed by nine other ministers. It pursued the strategy of institutional
innovation through its emphasis on ‘health action zones’, ‘healthy
living centres’ and ‘healthy citizens programmes’ as well as by its
endorsement of NHS Direct. And to confirm that the old ‘victim-
blaming’ spirit was still thriving, Saving Lives opened by reminding
readers that ‘individuals too have a responsibility for their own
health’.

The most significant difference from the past was that New
Labour’s health promotion initiative provoked virtually no
opposition and very little criticism. The medical profession, which
had been hostile to David Owen and ambivalent about Virginia
Bottomley, greeted Tessa Jowell’s policy with approval, if not
enthusiasm. The only significant problem encountered by the
government in this area resulted from external factors—it’s legal challenge to its
attempt to ban cigarette advertising.

Saving Lives did focus on one subject that had been
conspicuously avoided by the previous government—that of health
inequalities. The White Paper emphasised that the government was
‘addressing inequality with a range of initiatives on education,
welfare-to-work, housing, neighbourhoods, transport and
environment, which will help health’ (DoH 1999:x) Critics pointed
out that this wide range of government initiatives against inequality
did not include the provision of higher levels of welfare benefits. The
White Paper later asserted that ‘the strong association between low
income and health is clear’ and immediately added that ‘for many
people the best route out of poverty is through employment’ (DoH
1999:45). For the many people for whom that route was not
practicable, the White Paper offered no alternative. Given the
continuing controversy around health inequalities, it is worth briefly
tracing its evolution during the 1990s.

The concerns of the 1980s that increasing differentials in income
were resulting in a growing gap between the health of the rich and
that of the poor, became an increasingly prominent focus of medical
research and discussion in the 1990s. Encouraged by Donald
Acheson, the Kings Fund sponsored a series of investigations and
seminars which culminated in the publication of Tackling
Inequalities in Health in 1995, subtitled ‘an agenda for action’
(Benzeval et al. 1995). The BMA produced a report in the same year
recommending a wide range of economic and social policies in
response to this problem (BMA 1995). Both before and after its 1997 election victory, New Labour adopted the issue of health inequalities as one of its major themes, a preoccupation that is reflected in its public health policy documents.

At first inspection, the extent of medical and political concern with health inequalities appears puzzling. Though, as we have seen, class differentials have persisted, in real terms the health of even the poorest sections of society is better than at any time in history: indeed the health of the poorest today is comparable with that of the richest only twenty years ago (see Chapter One). Furthermore, it appears that the preoccupation with social class in the sphere of health (as indicated by the scale of academic publications) has grown in inverse proportion to the salience of class issues generally. After the emergence of the modern working class following the industrial revolution in the mid-nineteenth century, the question of class and its potential for causing social conflict and, for some, social transformation dominated political life. It appears that after this era finally came to an end with the collapse of the Eastern bloc and the Soviet Union in 1989–91, and the political and social institutions organised around class polarisation lost their purpose, the subject suddenly became of much greater medical and academic interest. No longer subversive, class had acquired a new significance in relation to the social anxieties of the 1990s.

A closer examination of recent debates about issues of class and health reveals some of the concerns underlying the discussion of health inequalities. Whereas in the past the working class was regarded as the major source of instability in society, that menace has now receded, to be replaced by a perception of a more diffuse threat arising from trends towards social disintegration. The government’s focus on issues such as crime and drugs, anti-social behaviour, teenage pregnancy and child poverty reflects its preoccupation with problems that appear to be the consequence of the breakdown of the family and of traditional communities and mechanisms for holding society together. All these concerns come together in the concept of ‘social exclusion’ which emerged in parallel with increasing concerns about health inequalities. At the launch of the Social Exclusion Unit, a key New Labour innovation, in December 1997, Tony Blair summed up the significance of the concept for New Labour: ‘It is a very modern problem, and one that is more harmful to the individual, more damaging to self-esteem, more corrosive for society as a whole, more likely to be passed down from generation to generation, than material poverty’ (The Times, 9
methadone maintenance is successful in reducing the wider damaging consequences of heroin use. In fact, some evidence suggests that it is most successful in reducing ‘drug-related criminal behaviours’, less so in reducing illicit opiate use and even less so in reducing ‘risk behaviours’ associated with the transmission of hepatitis or HIV (Marsch 1998).

The preliminary results of the major research programme sponsored by the Department of Health (National Treatment Outcome Research Study) similarly claim success on a variety of outcome measures, though not that of enabling the user to become drug free (Glossop et al. 1999). Researchers found that, after six months on methadone programmes (either in GP surgeries or specialist clinics), users had achieved a significant reduction in the use of heroin and other illicit drugs and a lower rate of injecting. It is scarcely surprising that if users are provided with opiates by doctors, their use of illicit opiates decreases. The survey also claimed an improvement in physical health, reduced levels of depression— and reduced rates of non-drug-related crime.

The BMA report emphasises the limitations of British evidence to date and the fact that much of the evidence guiding policy in Britain is derived from the USA (BMA 1997:76). The problem here is not only the difference of context, but that the American evidence is also disputed. Sociologist James Nolan has conducted a detailed study of the results of the Dade County Drug Court in Florida, the model for drug treatment programmes in the USA and beyond. He notes that while ‘initial findings regarding recidivism rates appear fairly impressive’—particularly when conducted ‘in-house’—‘studies conducted by agencies outside the Drug Courts, however, are less encouraging’ (Nolan 1998:104). Reviewing the figures and revealing various statistical scams, Nolan wonders whether ‘such liberty in adjusting measurements would explain the discrepancy between the low recidivism rates reported by the courts …and the much higher rates found by external agencies?’ (Nolan 1998:109). He also notes a tendency to adopt different measures of outcome, replacing the goals of staying off drugs and away from crime, with an acceptance of reports of participation and progress in therapy as positive indicators. His conclusion from careful examination of the conviction that drug treatment ‘works’, is that ‘it appears that the more subjective, emotive perspective has super-seded, or at least redefined what is meant by “it works”’ (Nolan 1998:112).
counselling may well be a desire to reduce contact with and responsibility for a very demanding group of patients’. One critic insisted that GPs ‘were not just avoiding “heartsink” patients, as the editorial suggests, but recognised the mutual benefit of bringing new skills and knowledge into the practice and extending the range of options within the primary care team’ (Jewell 1993). Counselling was one of those initiatives whose value was considered self-evident. Attempts to investigate its effectiveness were all very well, but should not be allowed to delay its implementation.

The provision of counselling in GPs’ surgeries was a radical departure with a number of significant features, not the least of which was the fact that it generally passed without much comment. It indicated that GPs were prepared to provide treatment, within the framework of the primary health care team, of a range of personal problems not previously considered to fall within the sphere of medical practice. Furthermore, they were prepared to refer their own patients to unregistered practitioners in a way which a few years earlier would have led to a summons to appear before the General Medical Council. As GP Myles Harris, one of the few critics of this trend, pointed out, ‘the idea of the medical register was to protect the public against untested therapies and counselling has no substantial agreed body of scientific evidence to back its claims’ (Harris 1994:24). Harris was concerned that doctors were turning their backs on their traditions of scientific medicine and ‘in allowing counsellors into the NHS we may be deserting medicine for magic’.

The fact that the government agreed to subsidise these counselling services indicated that it was ‘ready to treat ordinary human difficulties as illnesses’ (Harris 1994:6). Yet this also carried the danger of allowing the state, through the agency of counsellors, to define ‘what is “normal” in everyday behaviour’. The fact that counselling was already mandatory for HIV testing revealed the tendency towards compulsion that is often closely linked to the idea of normality. Harris rightly alerted GPs to the authoritarian implications of what was generally regarded as a beneficent policy.

The alternative to counselling was drugs—and the drug of the 1990s was Prozac. In the past doctors had been drawn into treating unhappiness with barbiturates (such as Seconal and Nembutal), in the 1950s and 1960s, and with benzodiazepines (such as Valium and Librium) in the 1960s and 1970s. Drugs from both groups had
Initiatives in all these areas are regarded as being at the cutting edge of progressive general practice and are likely to receive generous financial support from government and voluntary agencies. Any suggestion that this extension of professional intervention into the personal sphere, and the implicit shifting of the boundary between the public and the private, might have adverse consequences for the autonomy of the individual and the stability of the family, is dismissed as yet another voice of the forces of conservatism trying to hold back the tide of progress. Let’s look more closely at the role of the GP in the bedroom, the living room and the nursery.

**Sex in the surgery**

Shortly before the millennium, I was summoned to my health centre with invitations to attend a ‘sexuality training day’ on the subject of ‘sex in primary care’. Released details of the agenda promised ‘an opportunity to discuss [my] experience of sexual history taking, explore associated issues and develop and enhance [my] skills and confidence to discuss sex with a diverse range of patients’. Highlights of a day featuring games and role play included an ‘orgasm exercise’: ‘pairs to practice communications skills to talk about experience of or understanding of an orgasm’. Another exercise tackled ‘sexual language’: ‘small groups to brainstorm words for Male and Female sexual organs and homosexual/homosexuality’. The course included ‘a nice lunch and all course materials’(!).

My first response was to regard this course as rather silly and self-indulgent, as yet another example of the ‘dumbing down’ of postgraduate education. But, if we ask the question—how is a sexuality training day for GPs supposed to relate to their work with patients?—we raise a deeper problem. It is clear that the aim of the course is to overcome doctors’ own inhibitions in talking about sex so that they can in turn break through their patients’ reserve in these matters. Challenging doctors’ personal reticence is the key to opening up the intimate areas of ordinary people’s lives to professional scrutiny and interference.

The ‘Sex and the GP’ conference, one of many such training initiatives, is part of a wider campaign to encourage GPs to play a more interventionist role in their patients’ sexual health. In 1995, for example, the BMA Foundation for AIDS sent a complimentary copy...
for the primary care intervention in the family (Layzell, Graffy 1998; Goodhart et al. 1999). The project was developed by GPs working in collaboration with the Family Welfare Association, a voluntary organisation with roots in Victorian philanthropy. The FWA provided a ‘family support coordinator’, who was qualified as a health visitor and had undergone further training in ‘family therapy, solution-focused counselling and welfare rights’. Individuals or families, considered to be in need of psychological, emotional or practical support were referred by the GPs in a group practice and were seen by the family support worker in the surgery. Some were seen only once and offered information and advice or referral to another agency. Others received brief counselling over several sessions (between two and five). Around 20 per cent required longer-term support.

‘At a time when social services are overburdened in Britain’, observes Clare Goodhart, the GP heading the project, ‘family support in general practice offers one way to fill the gap’ (Goodhart et al. 1999). Many GPs might think that their surgeries were as overburdened as the social services and wonder whether it was their job to ‘fill the gap’ resulting from the inadequacy of local authority social care provision. However, initial reports suggested a high level of satisfaction with this project for everybody involved. For the GPs, the family support worker provided a point of referral for patients whose social or emotional difficulties were expressed in inappropriate requests for medical treatments. Patients liked being referred to a social worker within the surgery; the service was in a familiar and easily accessible place and, a point made repeatedly in the reports, it did not carry the stigma associated with local authority social services.

It is understandable that many of our patients, who are experiencing great difficulties in their lives, should welcome extra support from any direction. Yet, as the evaluation of the WellFamily project makes clear, ‘family support’ is not an entirely benign concept. The report indicates that, though there is no consensus over the definition of ‘family support’, there has been considerable debate about the relationship between this concept and that of ‘child protection’ and about the ‘appropriate balance between the two’ (Layzell, Graffy 1998:6–7). The authors appear to maintain a distinction between intervention where the primary concern is the safety of the children (‘protection’) and ‘preventative or early intervention strategies’ (‘support’). In other words support is being offered to families by the WellFamily Project as part of a strategy to
measures to strengthen the regulation of medical practice overlapped with the drive to implement new systems of quality control under the banner of ‘clinical governance’. The two key agencies overseeing this process—the National Institute of Clinical Excellence (NICE) and the Commission for Health Improvement (CHI)—opened for business in the course of 1999.

The government now adopted a higher profile in pursuing the reform of medical practice. In his party conference speech in September 1999, prime minister Tony Blair condemned the ‘forces of conservatism’—specifically referring to the BMA—that were holding back the government’s modernising reforms (The Times, 29 September). In fact, the forces of conservatism in the medical profession—indeed any forces of opposition to the drive towards tighter regulation—were difficult to discern. By contrast to its vigorous campaign against the Conservative reforms of the early 1990s, the BMA’s response to the New Labour initiatives was generally favourable. Indeed, the distinctive feature of the late 1990s reforms was that they were backed by powerful forces within the profession. Influential professional bodies like the GMC and the royal colleges were broadly in favour of the reforms (indeed, in substance, they had initiated them). Behind the appearance of a radical, modernising government courageously imposing change on a reactionary medical profession lay a different dynamic. In the course of the 1990s a growing sense of professional insecurity among doctors was expressed in the vogue for clinical audit, the drive to use the measurement of performance to improve standards, and in the demand for guidelines for clinical practice. Following the election of the New Labour government in May 1997, the internal aspiration to raise standards converged with the external imperative to modernise the NHS by strengthening managerial control and diminishing professional autonomy. Far from confronting entrenched ‘forces of conservatism’ in the medical profession, New Labour was able to enter a close alliance with a new medical elite that identified closely with its policies. By contrast with the powerful ‘forces of modernisation’ in the health service, voices of opposition were few, isolated and defensive.

To grasp the scale of the crisis of professional confidence that engulfed medicine in the 1990s, we need to trace its emergence over the preceding decades. In the 1960s and 1970s medicine faced criticisms from insiders and radicals; in the 1980s these were taken over and broadened by outsiders and conservatives; in the 1990s the profession turned on itself. Such was the ideological disorder of the
concluded by asserting that the political programme of the women’s movement should include regaining control over reproductive care from doctors who had taken it out of the hands of midwives and other ‘wise women’.


The anti-psychiatry movement drew support from a number of intellectual currents that emerged in the 1960s. Erving Goffman’s *Asylums*, subtitled ‘essays on the social situation of mental patients and other inmates’, first published in 1961, was a powerful indictment of the dehumanising effect of the psychiatric hospital, based on his own anthropological fieldwork (Goffman 1961). Thomas Szasz, an American psychiatrist, with a right-wing libertarian outlook, wrote a number of provocatively titled books—such as *The Myth of Mental Illness* and the *The Manufacture of Madness*—in an increasingly outspoken challenge to the psychiatric mainstream (Szasz 1961, 1970). From a radical existentialist perspective the charismatic Scottish psychiatrist R.D. Laing argued in a number of works, starting from *The Divided Self* in 1960, that mental illness was more a socially-prescribed label than an objectively verifiable disease and that psychosis could be a process of healing that should not be suppressed by drugs (Laing 1960). In France, the philosopher Michel Foucault, best known for his historical studies of the role of psychiatric institutions in the social control processes of bourgeois society, also became associated with the anti-psychiatry movement (Foucault 1961).

In the course of the 1970s, the ideas of anti-psychiatry were taken up by movements both of and on behalf of people with a range of psychiatric problems. They also became an influential current in the wider radical counterculture (for a brilliant critique of these trends see Peter Sedgwick’s *Psychopolitics*, 1982). Through television and film, they began to reach a much wider audience. In 1971 Ken Loach’s *Family Life* presented Laing’s theories on the causation of schizophrenia by dysfunctional family relationships. In 1975 Ken
curriculum’: this would include the familiar basic medical sciences, but also unfamiliar subjects such as ‘human relationships’ and ‘the importance of communication’. The extensive and detailed attitudinal objectives reflected the values of the culture of therapy and the demands of political correctness (neither previously a major influence on the medical mainstream). Students would be expected to show respect for patients’ diverse identities and rights, they should be able to ‘cope with uncertainty’ and they should display an ‘awareness of personal limitations, a willingness to seek help when necessary and an ability to work effectively as a member of a team’.

One of the key concepts of the new curriculum is that of ‘problem-based’ learning: instead of acquiring a grounding in basic medical sciences before encountering sick patients, students begin from a clinical problem presented by a patient and organise their studies around this problem (Lowry 1993:28–32). The idea is that, by being relevant to the resolution of a real clinical problem, their study of anatomy, physiology, biochemistry, etc. will be more interesting and better retained. The role of the teacher is no longer to transmit knowledge, but to facilitate the process of problem-solving by students, working collectively, in teams.

The defect of problem-based learning is that it assumes that defining a clinical problem is a straightforward matter, whereas in practice it is often profoundly difficult. According to Abraham Flexner, whose historic 1910 report promoted the reorganisation of medical education in the USA on the basis of scientific medicine, ‘for the analysis of the simplest situation which the ailing body presents, considerable knowledge is required’ (Flexner 1925:13) Furthermore, for practical treatment ‘still another volume of knowledge and experience is requisite’. Flexner explicitly rejected the method of proceeding on ‘superficial or empirical lines’ which is what is implied by the notion of the ‘relevance’ of scientific inquiries to the problem that has been identified. It is a commonplace that what appears to be relevant or important to the untrained eye is revealed by science to be merely a manifestation of some underlying phenomenon. Indeed, if what appears to be relevant coincided with what is actually important, then there would be no need for science.

Flexner offered a definition of science as the ‘persistent effort of men to purify, extend and organise their knowledge of the world in which they live’ (Flexner 1925:3). He particularly emphasised the word ‘effort’, insisting that students should ‘strive to transcend native powers, prejudices, limitations’. This approach stands in sharp contrast to that of the new curriculum, in which the
ending of the Cold War also brought to an end the polarities of left and right that had dominated parliamentary and electoral politics over the previous century. The unchallenged ascendency of the capitalist system meant that debates about policy became superfluous and government was reduced to administration. Yet, conservative propagandists immediately felt the loss of their old adversaries and were now forced to find new ways of securing popular approval for a system which had an inescapable tendency to generate social instability and dissatisfaction. In this wider context, intervention in health served a number of purposes. By projecting an image of concern about issues of health and disease, the government hoped to bolster its flagging legitimacy. It also welcomed a mechanism for establishing more direct relations with parties and thereby strengthening the authority of government over an increasingly fragmented society. Successive governments also sought to use these measures and more direct administrative reforms as means of securing tighter control over public expenditure on health.

When health becomes the goal of human endeavour it acquires an oppressive influence over the life of the individual. If people’s lives are ruled by the measures they believe may help to prolong their existence, the quality of their lives is diminished. The tyranny of health means the ascendency of the imperatives of biology over the aspirations of the human spirit. It provides the state, working both independently and through the agency of doctors and other health professionals, with a mechanism for extending its authority over the lives of each individual citizen and thereby over the whole of society.

Moving forward

How can we challenge the tyranny of health? Certainly not by clinging to tradition or by trying to return to that mythical golden age symbolised for many by the post-war NHS. It is not a question of going back, but of moving forward in a direction different from that charted by the current wave of reform. The first step is to clarify the specific features of our current predicament, in particular the links between, on the one hand, the tyranny of health and the crisis of medicine, and on the other, the stasis of the new world order that has come into being since the collapse of communism. A historical example may help to illuminate the distinctive character of the current moment.
government’s drive to curtail NHS spending on drugs and hospital treatment.

If doctors are concerned about restoring public trust, we should first recall what created public trust in the medical profession in the first place. This should lead to a renewed commitment to medical science and a determination to defend it against the anti-scientific prejudices which have recently become influential, not only in society as a whole, but more damagingly within medicine itself. It should also lead to a recognition of the importance of sustaining the personal doctor-patient relationship which has always been the bedrock of general practice, but is threatened by recent bureaucratic trends, not least by the drive towards revalidation.

The autonomy of the patient

According to GP philosopher Peter Toon, ‘autonomy has become a buzzword in medical ethics’ (Toon 1999:16). This concept ‘has been at the centre of the attack led by a recent generation of non-physician medical ethicists and patient representatives on the arrogance of medical paternalism’. But this narrow focus on doctors as the major threat to the autonomy of the patient underestimates both the impact of wider social and political forces on the doctor-patient relationship and the potential for doctors and patients to work together to combat the oppressive consequences of these influences.

We have considered two interlinked trends which have the effect of diminishing individual autonomy: the medicalisation of life and the politicisation of medicine. The first involves the proliferation of categories of disease to cover wider and wider areas of human experience and a growing proportion of the population. It also involves extending medical jurisdiction over diverse areas of personal and social life in the cause of preventing disease. The identification of more and more people deemed to be exhibiting some form of chemical dependency or psychological deficiency is another feature of medicalisation. By exaggerating disability and incapacity, this boom in diagnostic activity degrades individual autonomy and justifies professional intervention in personal life on a growing scale. Though the shift of doctors away from a focus on the individual patient towards a wider social and political role is often presented as a progressive development motivated by concerns to tackle the effects of poverty and discrimination, as we have seen, it tends to result in intrusive and coercive measures. Collaboration


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