Maltese Medical Journal, 1998; 10(2): 4
All rights reserved

GUEST EDITORIALS
The social face of medicine

Maurice N. Cauchi*

*Prof. M.N. Cauchi, Fgura Lane, Gharb, GRB 102, Gozo.

Our medical school has produced one generation after another of medical practitioners who can proudly stand with the best in the world. With considerable justification, we are proud of our medical school and its product, and many of us involved with it have striven to maintain this high standard, often in spite of, rather than because of the facilities provided, which have often bordered on the mean and the inadequate.

There are, however, lacunae with the medical curriculum which, one feels, need to be filled in to make it more of a whole. I have already had occasion to write about the need for a solid grounding in bioethical issues (Cauchi, 1997). We still do not have a set course of bioethics within the 5-year curriculum. The result is, in the opinion of some, an increase in shady activities by some members of the profession who opportunistically allow themselves to get involved in less than acceptable professional conduct.

Another aspect that has bothered me recently is the spate of criticism that has been gushing from sources interested in the social side of medicine. The physician has been accused of practising imperialistic medicine, lording it over patients with little regard for their autonomy (see for instance, Gerhardt, 1997). Physicians are seen to be indoctrinated in the so called 'medical model' of practice and ignore the fact that medicine should consist of team work involving a whole range of personnel. Above all, they say, medical students are taught only one way of looking at disease and at patients, thus ignoring the most fundamental aspects of all, namely that social pressures are among the prime factors that produce disease.

While many of these views appear exaggerated, it is a fact that our etiological classifications have been deficient in certain ways, and our pathogenesis has been found wanting. Perhaps the most vocal of all has been the group of Barker and his colleagues from Southampton, who, over the past decade, have been preaching the gospel that environmental factors in utero and early neo-natal life could mould the body and render it susceptible to a range of diseases in adult life. For instance they (and many others since) have shown that low-birth weight infants are far more susceptible to ischaemic heart disease and respiratory problems later on in life, compared to normal-weight infants. While we have been teaching students for decades that premature infants are susceptible to a range of developmental problems, we have not really placed any importance on the sociological factors that are primarily responsible for producing the low-birth weight infants in the first place.

Another aspect of this saga is the clear-cut distinction between diseases that affect the rich and those that affect the poor (Gerhardt 1989, Scambler 1987). This is perhaps best illustrated in the case of cancers, some of which, (like cancer of the lung, stomach and bladder) tend to affect those on the lower side of the socio-economic (SE) scale, whereas hormone-related cancers (breast, ovary, prostate) as well as colon and melanoma have been shown to have a predilection for those in the upper half of the SE scale. These are generalisations, of course, which relate to cancers in the western world, and exceptions abound. But they emphasise the importance of taking into consideration the social background, (and not just the trade or profession) in assessing the risk for certain disease processes.

There is no hiding the fact that the most horrendous medical problems are faced particularly by those in the lower SE bracket. They are far more susceptible to disease processes; they tend to be blissfully unaware of preventative measures and often tend to neglect therapeutic procedures. A case in point is cancer of the breast in black women in the US. While the incidence of this disease is less in black compared to white women, the prognosis is far worse for the former. In fact, 'ethnic medicine' is replete with examples of this sort of variation of disease severity with SE status.

There are many who consider (erroneously in my opinion) Maltese society as homogeneous and lacking the more obvious markers of social inequality. It is enough to consider that in some sections of our population the illiteracy rate is as high as 25%. And where illiteracy is rife, economic inequality is bound to follow.

Finally, in a country such as ours, where entrepreneurial zeal has dictated that practically all medical practitioners are involved in private practice of one kind or another, one must be particularly on the look out to determine to what extent fee-paying patients are treated differently from the rest. In other words, one might well ask, are we practising two types of medicine, one for the rich and one for the poor? We are lucky in Malta that we have a system of medicine that ensures that all patients get looked after reasonably well within our three public hospital system. Moreover, the private medicine provided by general practitioners and most consultants is still affordable by many, and we have not yet reached the extreme situation faced by some of the much richer nations, where absence of comprehensive insurance often means going without necessary investigation and treatment. Let us hope that in our efforts to introduce a general insurance system we do not divide the nation into those who can afford medical treatment and those who cannot.

The whole concept of medical education is to expose the tyro to an acceptable form of practice which hopefully they will follow and develop throughout their career. Overseas, social aspects of medicine are taught formally, and Chairs have been established for this

purpose. In Malta, social aspects of medicine are touched on in the course on Behavioural Science, and also in the module on Social Aspects of Mental Illness in Psychiatry. Issues relating to bioethics are treated in Seminars of Ethics in Paediatrics, and in occasional Bioethics Symposia organised by the Bioethics Consultative Committee (See Cauchi, 1998a,b). However, it is doubtful if these offerings are providing the necessary thorough grounding and commitment for all medical practitioners of the future.

Awareness of sociological issues, like bioethical issues, cannot be expected to be absorbed by students as by osmosis. The minds of future generations of students should be broadened to include formal teaching on the significance of a humane approach to patient care. Their education should give due importance to the relevance of the social structures of society and their impact on disease and medical practice.

References:

1. Barker, DJP. Fetal and Infant Origins of Adult Disease. BMJ 1992.

2. Cauchi MN. Ethics and the Medical Practitioner, MMJ 1997; 9(1),4.

The copyright of this article belongs to the Editorial Board of the Malta Medical Journal. The Malta Medical Journal's rights in respect of this work are as defined by the Copyright Act (Chapter 415) of the Laws of Malta or as modified by any successive legislation.

Users may access this full-text article and can make use of the information contained in accordance with the Copyright Act provided that the author must be properly acknowledged. Further distribution or reproduction in any format is prohibited without the prior permission of the copyright holder.

This article has been reproduced with the authorization of the editor of the Malta Medical Journal (Ref. No 000001)