

BOUNDARIES OF MEDICINE

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INTRODUCTION

The institution of medicine itself should have boundaries, like any social institution. However, determining what these boundaries are is more challenging than intuition would suggest. For example, there is growing concern that society is being medicalized to control deviant behavior (Conrad, 153), specifically when it comes to mental illness. The medicalization of mental illness implies “defining [deviant] behavior as a medical problem or illness and mandating or licensing the medical profession to provide some type of treatment for it” (Conrad, 153). An example of this would be calling alcoholism an illness and providing pharmacological treatment for it.

Mental illness itself is a broad and complicated thing to conceptualize. It has fuzzy boundaries and an ever-evolving core, but I argue that even without fully conceptualizing it, mental illness belongs in the medical field. This is so because mental illness is a form of human suffering and the goal of medicine is to alleviate this suffering. The implications of establishing such a broad goal for medicine complicate matters further, however. Beyond the argument that mental illness should not be a part of medicine is another, slightly different claim that mental illness is not a part of medicine because it is physiologically different from somatic illness (Szasz, 47). The latter is most famously held by Dr. Thomas Szasz but overlooks the intricate interconnectedness between physiology and the environment that renders the separation of mental and somatic illness impossible.

MEDICINE AND SOCIAL PRESCRIBING

Social prescribing is a relatively new trend in the healthcare professions that has the goal of “expanding the options available [for treatment] in a primary care consultation” (Brandling & House, 454). The idea behind it is to provide the patient with a variety of options for treatment that go beyond drugs and traditional medical intervention. It does not take away from traditional medical interventions or medication, but it adds to it by providing alternatives such as dance classes, horticulture groups, book clubs, sport clubs, and a wide range of other activities that create a huge array of treatment possibilities (Brandling and House, 454). This type of activity has been proven to have therapeutic value (Thomson et al, 8), though often it is left up to the patient to seek outside help in order to get involved in such activities. For someone living with depression

or a condition that is co-morbid with depression, the effort of finding a social group to join could be beyond what they can realistically do. This program creates connections between locally accessible community groups and patients in order to combat a variety of mental processes that can and do hinder recovery from mental and somatic conditions. The United Kingdom has the goal of beginning this program in 2023, along with setting aside an extra £1.8 million for the community improvements that will make the project possible (Cox).

Social prescribing takes on an integrative approach that George Engel would certainly agree with. Engel was an American internist and psychiatrist best known for the formulation of the biopsychosocial or BPS model (Cohen), a medical model that considers a patient's biology in addition to their psychology and social circumstances (Engel, 56). Social prescribing is an example of how medical professionals can take into account factors outside of physiology to improve a patient's disease experience. The program includes a facilitator who serves as a "referral agent" and ensures that the patient is getting as much as possible out of the program. It is designed to work within the patient's social, cultural, psychological, and biological needs in order to improve quality of life, beyond looking for the typical cure. Engel's model also requires clinical data to be established between psycho-socio-cultural factors and biology. The model shifts the focus from the biological or physiological components of the patient to the patient as a whole. Information on the extensive links between non-biological factors and illness or disease has been available for decades, but the medical profession had not yet gone as far as to use it in the way that social prescribing means to. The shift in focus to the patient's wellbeing is the goal of social prescribing. The BPS model also requires the acknowledgement of psychological and social factors as they relate to the patient's decision to accept the sick role. It requires treatment of the condition that goes beyond biochemical manipulation and also aims for a patient-physician relationship that fosters trust (Engel, 57-58). These three aspects of the BPS model are also a part of social prescribing. The program aims to provide psychological and social support that the patient may need in order to get through their treatment. It focuses on the combination of traditional medical treatment with therapeutic additions that suit each individual patient best, and it seeks to achieve a relationship where the physician has the role of "educator and psychotherapist," as Engel puts it, by providing numerous resources and encouraging the physician to look beyond tests and laboratory results.

The prescription of dance classes or horticulture groups could seem to be outside the medical field because these are social activities and not pharmacological treatments. However, social prescribing is still a way of improving a patient's wellbeing, making it not only a promising treatment option but also a part of medicine as a field. The reason for the latter is best explained in the work of philosopher William Goosens, who argues that the goal of medicine extends beyond curing diseases.

Goosens explained this nearly four decades ago; it is certainly not a new concept, but it is a challenging one to apply. The hard-medical model and evidence-based nosology that is commonly associated with medicine, especially in the western world, create the notion that medicine is meant to cure diseases. Several philosophers, including Goosens, have argued against this notion. In his paper "Values, Health, and Medicine," he argues that the goal of medicine is not to treat diseases but to focus on health as far as it concerns the well-being of the patient (Goosens, 104, 106). His argument is that medicine cannot simply be concerned with curing disease because there are instances where conditions typically thought of as "diseases" can be beneficial and would not be cured, for example, sterility in a person who is not interested in reproduction (Goosens, 103). He then explains that if medicine is committed to oppose and cure disease in the sense that disease is simply malfunctioning of the body, then the instances when disease is beneficial would also need to be cured (Goosens, 204). He then proposes that the goal of medicine is what is mistakenly characterized, as it should not be to cure disease, but to improve the well-being of the patient (Goosens, 106). Social prescribing fits well with Goosens's view of medicine because its focus is the well-being of the patient beyond the condition they might have. This focus on well-being is certainly essential for what the BPS model promotes as well.

It is important to note that the reason that social prescribing is feasible in this case is because it is being implemented on a social level. The United Kingdom has prioritized well-being, and specifically loneliness, by recognizing it as an important factor in mental and somatic illness. The same idea would likely fare differently if it were applied in the United States because the healthcare systems and the social perspectives between the two nations are different. Social prescribing in the United States would likely run the risk of being capitalized to create another for-profit segment of the medical industry. This is a limitation of the program of social prescribing as its success is highly dependent on social structures present. This is true of most programs implemented in fields like medicine and certainly a limitation of the project.

Regardless of limitations, however, the example of social prescribing serves to illustrate that with the goal of medicine being to improve well-being or alleviate suffering, the boundaries of the medical profession are extended beyond the patient's physiology. Certainly, expanding the boundaries of medicine must have implications beyond small-scale interactions with individual patients. One such implication is the role of medicine in public health.

MEDICINE AND PUBLIC HEALTH POLICY

Goosens makes another compelling argument in his paper. He recognizes that "no problem of the patient is isolated from his life as a whole" (Goosens, 106). Because of this, the medical profession has the obligation to give advice and treat while taking into account both the mind and the body of the patient. He further explains that it is those in the medical profession who is best equipped to deal with the workings of the mind and the body, as they understand both better than other professions. Finally, he says that "for doctors not to concern themselves with how the mind and the body affect general well-being is to leave this task to those less qualified [and thus] knowingly harm their patients as a whole" (Goosens, 106). This argument includes mental health and thus mental illness within the realm of medicine. The more general term of "well-being" certainly includes mental health. However, this is not readily apparent in every context and the line between what is considered a mental illness and what isn't can make matters worse. One key aspect to this argument is the fact that the health professions include much more than the general practitioners that serve as primary health providers. It includes other professions such as psychologists and counselors, as well as public health professionals like healthcare social workers and health educators. Many of these professions are interdisciplinary, allowing them to combine various areas of study for an integrated approach to complex health issues.

On November 20th, 2017, the American College of Physicians (ACP) released a paper titled "Reducing Firearm Injuries and Deaths in the United States: A Position Paper from the American College of Physicians [ACP]" in which the ACP made several policy recommendations with regards to firearms (Butkus et al, 705). The paper triggered a response from the National Rifle Association or the NRA in which the organization said, "Someone should tell self-important doctors to stay in their lane" (NRA). This comment triggered a strong response from the medical professionals who deal with the aftermath of gun violence on a daily basis. Many of them posted images on their

personal social media accounts of bloody scrubs or bloody operating rooms after dealing with a gunshot victim. The responses expressed the frustration of the medical community. An article on the story was posted on the social platform Reddit by the user and nurse 'ThisIsNotMyAOLname.' The post was made in the subreddit titled 'Medicine' where health professionals discuss relevant issues. Many of the comments mirrored the initial reactions of health professionals on other platforms; for example, an emergency medicine physician drew a parallel between the NRA and the cigarette lobby, suggesting an important conflict of interest that explained the NRA's contempt for physician opinion on gun violence (jello562).

If we consider gun violence to be caused by mental illness, Goosens would likely agree with that last comment, since his belief is that for medical professionals not to deal with mind and body problems leaves these issues to less qualified individuals, like the NRA in this instance, who have a clear conflict of interest regarding gun sales. The NRA likely overlooked the fact that the health professions include a wide variety of fields that extend beyond primary care. A very important group of them are mental health professionals, among which there are those specifically focused on public health policy. Not only that, but for decades gun violence has been linked to mental illness in media and policy. The NRA still stands behind creating a list of people with mental illness in order to restrict access to guns for this population (Metzl). However, research has led to the conclusion that mental illness is not as significant to gun violence in the United States (Metzl) as other factors are and that for this reason, policy aimed at mental illness within the context of gun violence would be ineffective. The only significant portion of gun violence directly related to mental illness is self-inflicted violence in the case of suicides (Metzl). Yet, I claim that with or without mental illness, mental health professionals and scientists should evaluate the links between gun violence and mental illness because they are better equipped to do so. This suggests that it is within the realm of medicine to evaluate possible links between mental illness and complex social issues, such as gun violence. However, this still does not necessarily suggest that making recommendations to bring the problem under control is within the realm of medicine.

In the cases above, the questions become: should doctors be licensed to deal with mental and social issues such as loneliness or alcoholism? And should doctors be allowed to suggest policy changes regarding social issues like gun violence? To the first question, the argument above responds, "yes!" These social issues have an effect on the person, and the goal of medicine is to relieve suffering. To the latter question, the answer is also "yes!" but for somewhat

different reasons. Mental health researchers and those directly involved in the acute treatment of violent acts, such as gun injuries, have fields of work that intersect with the treatment of those affected by gun violence. These physicians, psychologists, counselors, researchers, and more are focused on the people affected by gun violence, not on the revenue that gun sales bring within the United States. These physicians offer a perspective that should never be ignored. This does not mean that the policies suggested for implementation in the paper published by the American College of Physicians should be put into action without argument. Rather, it means that an issue that affects everyone, as gun violence does, needs to be the source of conversation among the various fields that directly deal with the issue. A Reddit user and medical student by the username of *agirloficeandfire* explained this by saying that as a health professional “you investigate the questions that affect you the most. There are those who work in these fields that have knowledge about possible solutions to these problems that directly affect their patients and their profession.” The majority of health care professionals in these comments agreed that issues affecting the well-being of their patients should be part of what medicine and they, as health care professionals, medicine are concerned with. Public health policy is also within the realm of medicine because it is an issue affecting the people on whom health professionals focus. Complex social issues also require that other professionals contribute to their understanding, meaning public health issues are not exclusively within the realm of medicine, but certainly not outside of it.

There is an important distinction here in that the medical field should have an opinion and concern itself with social issues that affect its patients and professions, but it is not up to medicine alone to implement change. A physician is not obligated to solve their patients’ social problems, even if these cause a patient’s lack of mental and physical wellbeing. This, however, is a fine line that is not easy to delineate when conceptually defining the goal of medicine as relieving individual suffering or improving well-being. The goal is so broad that almost anything can be included. If the goal of medicine is to relieve suffering, then are medical professionals obligated to do everything in their power to help their patient? Should they feel obligated to donate a kidney to a patient in renal failure who cannot find a donor? Should they feel obligated to pay out of pocket for medication that their uninsured patients cannot afford? I claim that the answer is no, but I recognize that declaring medicine as the field that concerns itself with relieving suffering does not delineate these limits well. Practically speaking, it is simply impossible to do right by every patient

and fulfill every need the patient may have. However, both donating a kidney and providing end-of-life care are ways of relieving suffering. A physician may choose to go above and beyond for their patients but that is being done as a fellow human being, not as a medical professional. How much a physician is required to do is hard to determine. The answer likely depends on both cultural and personal factors, meaning it will vary by place and time. This problem, however, does not take away from the argument that medicine is concerned with the patient as a whole.

Another problem that needs to be acknowledged is the relative term “suffering” in the definition discussed so far. The experience of suffering will vary from person to person. This could become a problem when for patient A, suffering means mental illness in the form of severe depression, and for patient B, suffering means the inability to compete with peers due to a relatively lower IQ, perhaps an intelligent young man trying to compete with prodigy mathematicians. Patient A undoubtedly should receive treatment, but should patient B? The intuitive answer is “no.” But the reason why is hard to explain. It is certainly not up to the medical professional to decide when a patient is suffering enough to receive treatment. Even when the treatment is pharmacological in nature, there is a complicated rationale for saying “no” in this case. My inclination here is to argue that cases such as that of patient B depend on a judgement call that takes into account other circumstances in the patient’s life. Does the patient have access to tutoring or academic resources? Does the patient also have a full-time job and pay for their own schooling? Is treatment something that could help without causing long-term negative effects? With the focus on well-being and the goal being to relieve suffering, many cases will fall in a grey area, leaving it to the physician and ethics committees in the field to honor their goal and determine what should be done to the best of their ability.

MEDICINE AND MENTAL ILLNESS

Dr. Thomas Szasz, a psychiatrist and academic, developed a controversial and interesting argument regarding mental illness and would disagree that mental well-being is part of the medical field. In his work, “The Myth of Mental Illness,” he argues that contrary to somatic illness, mental illness is defined as a deviation from a social norm, which is itself defined in terms of “psychosocial, ethical, and legal concepts” (Szasz, 45). According to Szasz, this means that “it is logically absurd to expect [medicine] will help solve problems whose existence

has been defined and established on nonmedical grounds” (Szasz, 46). He ultimately argues that mental illness is simply not in the same realm as somatic illness and should therefore be “removed from the category of illness” (Szasz, 46). His argument implies that mental illness is outside the field of medicine, not because of the reasons discussed by Conrad (defining mental illnesses as part of the medical field to control deviant behavior) but because mental illness is simply different from somatic illness and it is only somatic illness that belongs within the field of medicine. Dr. Szasz’s argument relies on the premise that medicine as a field has the goal of correcting an illness defined as a deviation from a clearly defined, presumably physiological, norm (Szasz, 45). This premise, however, is wrong. His view is more in line with a hard, evidence-based model of medicine than one which includes the psychological and social factors that Engel highlights in his BPS model.

I argue that Dr. Szasz is wrong to rely on this premise because research has shown a clear physiological link between what he calls “problems of living” and somatic processes. There is biochemical evidence for how social and psychological factors affect biological processes in the body. For the purposes of this argument, the mind is essentially the collection of processes that make up an individual, including biological, social, cultural, psychological, and environmental processes. These are all interconnected, and research is showing increasingly compelling evidence that epigenetics could be a possible and more tangible connection between the mind and the body. A compelling example for this is a study done in 2013 in which the researchers found that if a mouse was taught to associate a certain smell, in this case acetophenone (smells like almonds), with the painful stimuli of a foot shock, their progeny would also have this response to the same smell without having been exposed to the pairing of acetophenone and foot shock (Callaway). The mechanism for this is an epigenetic one, where the DNA in the parent mouse undergoes a change that does not affect its genetic sequence but does affect the way genes are transcribed and translated to form protein, thus affecting behavioral responses. This is thought to be how instincts evolved (Callaway). This clear link between environment and biology shows that outside factors are not completely cut off from biology. This does not mean that mental illness is simply the same as somatic illness or a part of somatic illness, as Szasz would likely suggest after presented with epigenetic data. Mental illness is a complex set of processes that are not quite understood yet and may never be understood, that deal with who an individual is within their context. Somatic illnesses are part of health, just like mental illnesses. If any of the two will

encompass the other, it would be mental encompassing somatic in a complex cross-talking system that makes up a human being.

CONCLUSION

Dr. Szasz's assumption that biology is completely separate from other areas of life is mistaken. Epigenetics is only one of the reasons this premise is wrong. All of the healthcare fields are interconnected, and it is because they are interconnected that the biopsychosocial model is the best approach for medicine yet. It is because of this same interconnectedness between the social, psychological, and biological that the goal of medicine cannot simply be to correct deviations from illness. Instead, it must be to focus on the patient's well-being. This tangible interconnectedness is what supports Goosens's view that "medicine is not concerned with disease alone" (Goosens 104). It is the link between all aspects of life that makes mental health a medical issue and what suggests that social issues such as gun violence are part of the public health arm of medicine. The field of medicine does have boundaries, but mental health and related public health issues are certainly not outside these boundaries. Medicine is a deeply human endeavor, and it is because of that nature that the boundaries of the field extend beyond somatic illness and the cure of disease. Limits do exist, but it is only when an endeavor is dehumanized that it has crossed into a field outside of medicine's realm and jurisdiction.

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