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The end of medicine. The problems of social construction

El fin de la medicina. Los problemas de la construcción social

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ABSTRACT

This article addresses the differences between social context and social construction, and the influence of each on what we consider knowledge, the purposes, and the practice of medicine. It describes the validation processes by which we consider accepted medical knowledge, how anomalous combinations between context and social construction produce justifications that influence what doctors and patients expect, and how, by changing the foundations, ends and practices also change. Finally, the consequences of a lax moral pluralism are discussed, in which physicians relegate their functions to patients, then left unattended and at the mercy of their beliefs.

RESUMEN

Este artículo aborda las diferencias entre contexto social y construcción social y la influencia de cada una en lo que se considera conocimiento, en los fines y la práctica de la medicina. Se describen los procesos de validación por los que el conocimiento médico se considera aceptado, cómo combinaciones anómalas entre contexto y construcción social producen justificaciones que influyen en lo que médicos y pacientes esperan y cómo, al cambiar los fundamentos, cambian los fines y las prácticas. Finalmente, se discute un pluralismo moral laxo en el que el médico relega sus funciones al paciente, quien queda desatendido y a merced de sus creencias.

INTRODUCTION

The proper approach to the study of the ends of medicine requires addressing different contemporary philosophical influences. To name one, the attitude against scientific positivism, constructivism —which maintains that reality is constructed by those who observe it— and the relativism that results from it.

On the other hand, there is a peculiar schizophrenic social attitude, one of distrust in science and at the same time of an attraction to technology bordering on reverence, and an avidity almost indistinguishable from dependency, with a minimal social disposition towards understanding it and even less curiosity —yes, it is possible— to understand both. A naïve attitude of fear of medicine and love of technology, which does not allow one to conceive them as two aspects of the same thing. Medicine, the aims of medicine, and medical ethics also do not escape confusion, the schizophrenia of a vegan techno-geek. The physician who practices in such a society can also split his rationality when confronted with the preferences of a given patient.

There are two perspectives from which we can attempt an analysis. The first one from the contemporary social context of a complex health system, in Mexico completely failed, influenced by interactions between public institutions and their policies, and between established medical bodies and the industries that provide drugs and supplies, also influenced by insufficiency and shortage, which force patients to look for elsewhere for *alternatives*. In the gnoseological aspect, a context influenced by the statistical, intuitive, or imaginary nature

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of what doctors and patients consider accepted knowledge, in which rational, emotional or frankly irrational standards of proof intervene, between rigorous reasoning and the joyful consent of beliefs. A context also influenced by medical illiteracy.

The second perspective from which the analysis can be made dates from the Hellenic era and has focused on the relationship between the disease, the patient, the physician, and the act of healing, the nature of which, to be deontological, first requires being phenomenological. The encounter with the patient justifies an investigation of this relationship between subjects, to elucidate whether the end of medicine depends on a social context or if it is teleological; that is if the purpose of the medicine is of a broad-spectrum or specific to each patient. It would also be necessary to specify who, and how they establish that end if it changes with a pendular movement, who and how to decide the momentum, and the type of change — if the spectrum is opened or closed.

The anomalous relationships between social *context* and social *construction* can easily confuse a non-rigorous physician in the selection of his study sources, or allow the pragmatic and lenient physician to play along and choir the patient who, faced with the threat of disability, pain, and death, turns to "healing options" that are neither healing nor real options. This paper frames the first perspective, the end of medicine from a social *context* versus social *construction* as an "epistemic contaminant".

THE SOCIAL CONTEXT

It is well known that medicine is a team task in which different professionals enter and exit a relationship with patients, depending on the level, severity, and stage of their illness and needs. Professionals have obligations to patients that derive from the aims of the profession itself, analogous, and which overlap with the ends of the individual physician. This complex social context, its limitations and deficiencies influence how doctors and patients act and react. There is, however, something common to these experiences, transversal to cultures, places, and times. Regardless of whether the relationship is personal or social, the crux of the matter, its foundations, reside in the encounter with the patient, the profession of the physician, and the act of healing.[1] Equally important, when it is not possible to heal, care and palliation also take primacy in the well-being of the sick. *Social context* influences the practices, the evaluation of what can be good, or at least correct, at a social scale, without generalizing at an individual level. This does not mean that context dictates the ways, nor that it is the defining parameter of the aims of medicine in all its range, from the entire society to the individual —metaphorically said— from a macro- to a microcosm.

But it is one thing to practice medicine in a *social context*, and quite another to practice it guided by *social construction*. There is no logical relationship between the fact that medicine is a social practice, and therefore in a social *context*, and the conclusion that the way to define medical knowledge is through social *construction*.

In a social *context*, the social *construction* of medicine intervenes as an "epistemic contaminant", which I define here by analogy as a substance *X* where it should not be, or in concentrations above background conditions which can produce biological effects, understood here as the reactions of an organism, population, or community, to changes in the environment caused by *this* contaminant. *X* can be replaced here by whatever idea propagated by non-scientific literature, pseudo-documentaries, infomercials, rumors, anecdotal evidence, miracles, and portents. None of the above has explanatory power on natural phenomena.

The immediacy and ephemerality of trivial and useless information come from the most varied and least authoritative sources on a topic and can shape beliefs about a true or false fact. These are ideas with little or no support on demonstrable facts which, accepted as knowledge with a bland rationality, shape behaviors. Epistemic contaminants, syncretisms of revived outdated theories, attitudes, doctrines, and opinions without proof, cause harm. Illiteracy, medical or other, also causes vulnerability and harm.

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THE PROBLEMS OF SOCIAL CONSTRUCTION

That something is socially constructed means that it would not have existed if had we not produced it, that it would be different had we lived in a different society, it means facts in the world are caused by social forces. In this sense, ideas, knowledge, what we call "human nature" are social constructs that respond to different needs, interests, and values. The socially constructed has to do with our beliefs about things, how they are generated, and take shape by social forces.[2,3]

From the above, the contrast is clear with natural objects and processes that exist independently of us and we cannot model. Bacteria, viruses, and neoplastic cells exist in the natural world, they are independent of our societies, not a product. Although technology allows us to modify some of them, they exist before societies existed. Diseases, which are not social products but natural processes, do change their course according to our behaviors. Social processes can modify natural processes.

We have to be careful with some postmodern arguments whose limits between the objective and the subjective have become blurred. As rhetorical tactics, these arguments are used to undermine or relativize concepts such as 'knowledge' or 'certainty' . The argument that something is a social construction is incomprehensible because of its vagueness. Its explanatory purpose is analogous to a broad-spectrum antibiotic. A broad-spectrum antibiotic kills (almost) everything. A neglected, misapplied or downright ill-intentioned social construct provides broad-spectrum explanations and kills (almost) every need for an inquiry.

But neither the existence of things depends on our perception[4] nor can we validate the existence of anything by mere belief or faith. There are also no innate objects in the mind; we cannot construct mind-objects without some prior perception or empirical confirmation. *Nihil est in intellectu quod non prius fuerit in sensu*, there exists nothing in the intellect that was not perceived first by the senses.[5] There is nothing intrinsic in things, as objects, that reveals their existence to us. In contemporary science, entities are postulated by different methods that we use to conceive them, understand them, represent them, and demonstrate their actions, and are confirmed by technologies and techniques derived from them to initiate or intervene processes.[6]

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Physiological and pathological processes, and technologies, regardless of whether understood by physicians and patients, affect the natural history of diseases in such a way that neither knowledge nor medical practice are wars of subjectivities between doctors and patients, although it may sometimes seem so. Frequently, despite the evidence, acceptance of such processes is subjective, albeit not always intersubjective, not always shared by others. Strange amalgams of context and social construction are produced, anomalous justifications of beliefs that, in individuals not experienced in science, acquire the status of knowledge without hesitation.

Practices, the medical art as such, are not what each patient or social group would want them to be, despite a popular epistemological pluralism denoted by euphemisms such as 'democratic knowledge' or 'popular knowledge'. Good medical practice is also not the common sense of "reasonable people" but the rational performance of the studious physician, critical of their sources. We can then glimpse the ambiguity of terms and the confusion of constructed expressions as 'democratic knowledge', 'popular knowledge', 'reasonable people', common places being accepted for their ease, for the emotional charge of placebo they carry, and for the lack of rigor of physicians who do not have academic or philosophical obligations but do have the duty of treating patients appropriately. These confusions are of fundamental importance because physicians are also subject to the influence of socially constructed ambiguous expressions and concepts.

Taking an object or situation as existing "*means* precisely being predisposed to have my relationship with the world determined by that object or situation." (*Italics* in the original). It is possible to believe in objects represented by the imagination or understood by the mind although they do not exist; it is possible to believe false facts.[7]

It is important in the analysis of social construction to confront its central point, not to ask about its meaning, but its object, to ask the social construction of what? An always pertinent question is what the point (the object of that construction) is if it is used to raise awareness of a problem or to explain processes and states of affairs.[8]

A social construct can also be used as a mere rhetorical instrument, not to raise awareness of a problem but to create needs. A non-trivial example, health is not the same as a healthy lifestyle. It is possible to have healthy habits and an underlying disease, either hereditary or consequence of previous bad habits. It is also possible to be healthy and suffer a socially constructed fear of a disease. In this latter case, we would be talking of the social construction of fears and promises.

The knowledge of the physician can conflict with the knowledge of patients and end up yielding to ends not necessarily in the best interest of the sick. Neither doctors nor philosophers are one hundred percent objective, as science and the Anglo-Saxon philosophy of science of the first half of the 20th century postulated, purportedly "free from all possible psychologism."[9] What is considered accepted knowledge is also not 100 percent objective, nor does it automatically emerge from meta-analyzes or publications. Consensus, practice guidelines, official norms and recommendations are not mere sympathies between researchers, but more complicated evaluation processes among research groups,[10] although there also exists a "consensus fallacy"; an achieved consensus is neither true nor is it incontrovertible.

In science, everything is revisable, provisional, and changing, and although the physician should always bear this in mind, a patient need not question their beliefs. From the firmness of these, however ill-founded, they can question the physician, medicine, and ultimately, science. Against the fear of disease, patients need not bear the burden of proof, they need the tranquility of their beliefs.

THE ENDS OF SOCIAL MEDICINE

Social medicine "is the art of preventing and curing, considering its *scientific bases*, and its individual and collective applications, from the perspective of the reciprocal relationships that link people's health to these conditions."[11] (*Italics* added). Its purposes are to understand the effects of different social and economic environments and to modify their adverse effects on the health of populations. It is difficult to define health, it is more than the mere absence of disease; however, it is a state of affairs that can be evaluated by indicators, controversial albeit with objective parameters.

The ends of social medicine are not the same as *socially constructed ends*, such as the so-called healthy lifestyles, which have all the subjectivity of induced personal preference. In the same way, as the research collectives mentioned are psychologically conditioned communities, so are different non-scientific social nuclei. The former, by theoretical postulates, test standards, experimental replicability, peer review, statistical, and meta-analytical methods; they are conditioned by confirmation, controversy, or falsifiability of their statements. The latter are conditioned by true or fictitious needs considered as certain, produced by marketing and advertising as illusions against the uncertainty of life, against a perceived and exacerbated fragility. Socially constructed medical ends are the consequence of an illusion of longevity and distancing from death.

So medical knowledge is not what a given social group wants. Social construction, without methodological filtering, does not allow stable theories about the nature of things, nor does it allow —nor does it need— predictions. Certainty is a virtue of faith; social construction provides it.

However, neither can a lenient moral pluralism be derived from the above, in the plain sense and customary fashion of to each its own, since the physician would be abandoning their functions to the unattended discretion of patients and relegating their role as guide and caregiver. The relationships between social *context* and social *construction* require the physician a careful analysis.

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THE END

I finish with a matter as controversial as it is unequivocal, the patient cannot always

know, even if they sense it, what is best for them, and their decisions are not always as autonomous as they would like. Their autonomy may be nothing more than a social *construction* in a social *context* in which they are not autonomous. It is possible that with little understanding they claim their autonomy as a construction, wanting to escape, with little possibility, from their context. Therein lies the tension of the relationship and the conflict of subjectivities and desires between physician and patient. However, it is in the individuality of each patient, not that of the physician, where the teleological element resides, the end of medicine, the subject of the next communication.

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