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Review
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MEDICINE IN THE ERA OF DECIVILIZATION

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Summary

This paper discusses the current trends in the development of medicine. In the first part of the article several of the major societal trends affecting medicine are enumerated and discussed. These include the processes of decivilisation (the decrease of care and attention that a society gives to its feeble members), globalisation, commoditification (the tendency to consider health and health care as well as many other social concerns as commodities such as sugar or cotton), decentralisation of social services, the changes of the middle class, the technological revolution and the consequences of migration and population movements. The second part of the article deals with the changes of medicine and of medical ethics, with changing goals of health systems, with the obsolescence of important health care strategies and with changes of the systems of medical care. Burn-out of health care personnel and the impact of the imposition of novel value systems by globalization are also briefly discussed. The paper ends underlining the need for a re-examination of the health care strategies, involving all the stakeholders in the field of health – representatives of family and patient organizations, governmental sectors other than health (e.g. education and labour) the health industry and the many categories of health professionals – in order to bring these strategies in harmony with the development of society as a whole.

Key words: development of medicine; globalisation; decivilisation, technological revolution; health case strategies.

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decentralisation of social services, the changes of the middle class, the technological revolution and the consequences of migration and population movements. The second part of the article deals with the changes of medicine and of medical ethics, with changing goals of health systems, with the obsolescence of important health care strategies and with changes of the systems of medical care. Burn-out of health care personnel and the impact of the imposition of novel value systems by globalization are also briefly discussed. The paper ends underlining the need for a re-examination of the health care strategies, involving all the stakeholders in the field of health – representatives of family and patient organizations, governmental sectors other than health (e.g. education and labour) the health industry and the many categories of health professionals – in order to bring these strategies in harmony with the development of society as a whole.

Changes of society: a selective review of developments relevant to medicine and its practice

The development and practice of medicine depend on the society in which they happen. A brief review of trends in societies of the world might therefore be helpful. Not all of the current social and economic trends can be reviewed here and therefore a brief mention will be made only of those that are most likely to have a profound impact on medicine.

Decivilization

The level of civilization of a society can be measured by the amount of care that the society provides to its most vulnerable members – the elderly, the disabled and children, for example. Decivilization refers to the process of reducing such care thus allowing those who are less able to defend themselves to perish. The last decades of the twentieth century seem to be characterized by decivilization indicated by facts such as the increase of child mortality in countries that have previously been proud of their mother and child protection programmes, continuing shortages and reductions of resources for public health programmes and the monetary and health care difficulties experienced by those retired.

Globalization

Numerous other processes – partly related to decivilization - have also been characteristic of the late 20th century. Globalization, for example, was one of them. Globalization was expected by many as a long awaited opening of borders, free circulation of people and ideas, compassion among people and countries, a

growing awareness of and respect for value systems of others, an opportunity to learn and to teach about ways of better living. Unfortunately many of these dreams and expectations remained dreams and some turned into nightmares. Globalization has often led to the imposition of value systems of those powerful and rich to those who have less. It has made many aware of how little they have and how much they could have but will not get. It has introduced one-way flooding of markets with the least beautiful of products. It has killed local industries and created a new urban proletariat which had almost disappeared in the developed countries and was hardly known in the less developed parts of the world. It has not reduced poverty in the third world countries nor has it enticed the rich countries to increase their help to the rest of the world. It has eroded traditional ways of dealing with trouble and distress and proposed new ones incongruous with the culture and expectations of people.

Commoditification

The emphasis on economic growth and self-sufficiency has also led to commoditification – a new term that describes the tendency to consider health care and other social services as commodities – such as sugar or cotton. Commodities are bought and sold, the best deal being to get good quality products at a low price or to sell a product for more than it is worth. Providing health care – a task that in the late nineteenth century and throughout the first eight decades of the twentieth century has been considered as an ethical imperative and a goal which societies should try to achieve – became treated in the same way as any other commodity that societies produce. The tendency to provide the cheapest form of health care became so attractive that it continued to be pursued even when this lead to less favourable outcomes of treatment than would have been possible if more resources were devoted to care. The notion that health care should be provided even if that does not make money became unpopular. Budgets for the maintenance of and services of institutions for the elderly, for the mentally retarded, for the chronically ill and others whose prognosis was not encouraging were reduced because it was not likely that the inmates will become economically productive. In an increasing number of settings it became more and more necessary to be rich in order to find decent care for a chronic long lasting disease with poor chances of recovery.

Decentralization in the social service systems

Another development hailed in the mid-twentieth century as a terribly important innovation was the decentralization of social services such as health.

The main argument for it was hypothesis that this will increase the motivation of those working in the peripheral services. They will, it was said develop a feeling of ownership of their service and this will make them pay particular attention to the quality of service and to its appearance. The long wait for decisions from above will be removed. Requests for reports and silly orders demonstrating that those far from the working places do not know what goes on will not be showering on the first line workers. Unfortunately things turned out differently and the emphasis on decentralization proved to be less than useful for the function of services. In many instances the decentralization was interpreted as the decentralization of responsibility without a decentralization of authority. Thus, while the peripheral workers had to find ways to resolve problems on their own the decision about resources and the approval to spend them remained at the centre.

Changes of the middle social class

The gradual decrease of the size and strength of the middle social class in the developed countries had negative effects on the quality of life of an important part of the population. More importantly however the erosion of the middle class also led to an erosion of morals that have governed industrialized countries over the past two centuries. The middle class has always been the defender of the moral of society: its diminution reduced the assiduity in the application of moral rules in society and led to the weakening of those prescriptions that were particularly important for the survival of society in times of distress – including for example, the obligation to provide help to those in trouble, respect of social hierarchy and the acceptance of caring for members of the family struck by disease or weakened by old age or other causes of functional impairment. The extreme social classes – the rich and the poor – in previous times lived by their own, often idiosyncratic rules that were different from those of the middle class: as the middle class lost its power these rules became more prominent and imposed legal and social puzzles to the governance of the society. Thus for example, common law marriage was very common among the poor but rare and disallowed by the middle class: now that it is becoming frequent, particularly among the young, a variety of arrangements based on the marital contracts – from the obligation to contribute part of the couples budget to the schooling of children to the obligation to help in caring for sick relatives – are becoming uncertain and unreliable.

The size and strength of the middle class has also changed in the developing countries. Although the proportion of the population that has reached the

level of middle class is small, the total numbers of those in that class are large. If, for example, in India 20% of the population reaches the level of the middle class there will be more than 200 million people in that class – far more than in any of the developed countries. It is of course true that even if 20% were to rich the level of the middle class some 70% of the population might still be living in conditions of great poverty: this however does not change the fact that the 200 million middle class Indians represent a huge market and a formidable social force. The middle class citizens may, for example require better health care and will, if the government does not provide it, erect a private health care system that will exist in parallel with the health care system created by the government. The private health care system is usually of much better quality and its existence makes those who can not accede to it and have to rely on the poor quality public health system very unhappy. Primary health care introduced at great cost (and relying on personnel often trained in condition of scarcity and therefore often less competent) loses its attractiveness for those who should rely on it and participate in it. Social cohesion is also affected by the growth of the middle class often separated from the rest of the population by the creation of elegant districts of cities protected from others, less fortunate citizens, by high walls and armed guards.

The technological revolution

The technological revolution and in particular the amazing advances of the technology of information management has also contributed to the changes of societies. The modern media bring the same information about events – catastrophic and other – into the vast majority of households worldwide. Internet opens the doors to a world of information about all possible subjects including diseases and their management. Surgical operation that could previously be only seen in science fiction movies are often performed in provincial medical centres. The new and modern "exoskeleton" of humans – allowing a single worker operating a crane to move hundreds of tones of material and making it possible to fly thousands of miles in metal boxes called airplanes makes incredibly complex and difficult feats normal and expected.

Unfortunately however, the new technology has not sufficiently reduced the distance between the rich and the poor: the new apparatus is not evenly available or used by all. The per capita number of personal computers, for example is much higher in the developed than in the non-industrialized countries. Those who can afford to purchase computers also have access to training in their use. Those well of can use the fast and safe vehicles of transport which are much

more costly than those old, dangerous and slow which have to be used by the poorer people. The distance between those poor and uneducated and those who had education and resources to use the new technology is growing. The disadvantages of the poor and the advantages of those better of are accumulating and lead to an increase of inequity and consequent malaise and social disruption.

Another, unexpected consequence of the introduction of information technology into everyday life is increasingly apparent in many countries and particularly among those of younger age. The possibility of communicating with others by machines reduced the use of social and interpersonal skills to the point that they are forgotten. In some countries – Japan for example, a significant number of young people remain restricted to electronic communication with others or with the anonymous world-wide-web: the contacts with their parents is reduced to a minimum and often begins and ends at accepting the food that is being offered. Direct social contacts with others have ceased. The hikikomori syndrome - as this behavioural style has been labelled - has struck some 1.5 million adolescents: reports from other countries indicate that the problem is not exclusively Japanese but may be a real menace to all of the world's countries. Hikikomori is an extreme form of a much more common phenomenon significantly affecting the amount of social capital that a society has [1]. Food and other necessities are ordered by telephone. The contacts with family members are restricted to electronic communication. Young people will make suicide pacts with others whom they have never seen (and with whom they have only internet links) and then kill themselves at set time. Friends are not invited to come to one's home to share food and talk any longer. Telling jokes has become an almost extinct skill since television brought the world's best comic actors into everyone's home. Communication among colleagues having offices next to each other is done by email. Courses for young professionals now have to include the learning of skills which were, in previous times an essential part of the education at home, living with siblings and various family members. The developing countries are somewhat better off in this respect: but it is clearly probable that similar trends will also become apparent in those lands, at present still largely depending on interpersonal and emotional links and communication.

Migration and population movements

Finally, another trend should be mentioned in this selective review of modern tendencies affecting the practice of medicine: it is the continuing increase of the mobility of individuals and populations, across the globe. Migration

does not stop at the move of people from one place to another. Migrants bring their systems of value with them and these are sometimes incompatible with their hosts' cultures. They also bring their diseases or the ways in which diseases express themselves in other parts of the world. In travel, the latter often change and become different from the expressions of the disease in the home and in the host countries leaving the health workers of both countries baffled and uncertain about the treatment and about other measures they should undertake.

Migration across borders is more visible and its effects are observed with more attention than the migration within borders. A huge proportion of the population, particularly in developing countries is moving to cities contributing to the rapid urbanization of the planet. The most urbanized country of the world – Argentina, with more than four fifths of its population living in cities – was until recently a country whose strength and population were outside of urban areas. Countries such as China had a vast majority of its population living in rural areas until very recently: now nearly half of its citizens have moved to towns. Urban population require a system of health care that is different from that serving well in rural areas: while this fact is recognized by many there is still no well articulated generally accepted strategy of urban health care. The operational prescriptions of primary health care that the World Health Organization has been promoting over the past forty years are appropriate for use in rural areas of the world: they do not have their counterpart in a primary health care strategy for use in urban areas [2].

CHANGES OF MEDICINE: TRENDS AND CHALLENGES

Change of the nature of medicine

Priests responding to the pleas of persons suffering from an illness and seeking help in temples were the first medics, creating bridges between the supplicants and the divine. Herbalists were consulted as well: but their craft was considered as any other craft, lower in status than the help from sacred places – a division that is reflected to this day in the relative position of physicians and pharmacists.

When the priests were replaced by lay physicians the latter took from them the magical wand of healers. Not everyone could become a physician: one had to have a calling, a vocation to become a healer. In many developing countries to this day alternative medicine practitioners are not becoming healers because they have followed a particular course or other form of education but get their position because they had a calling. The vocation of medical doctors gave au-

thority to the practitioners and imposed duties best formulated in the Hypocratic oath and maintained in the traditions of apprenticeship and learning how to deal with illness. Having a vocation also meant that the practitioners were to give preference to moral rather than material gains; it further meant that the qualification for the practice of healing depended to a greater degree on the gift than on strictly regulated training.

In the nineteenth and twentieth century, in parallel with the reforms of societal structure, continuing industrialization on a large scale and the increased emphasis on the need for a clear definition of social roles, medicine started changing from a vocation to a profession. The concern for a standardization of medical training emerged in parallel with rules of behaviour and the creation of professional associations protecting their members but also expecting their adherence to a certain code of behaviour. The professionalization of medicine gradually surpassed national borders and organizations such as the World Health Organization spent a number of years trying to define physicians – by defining their clients, their treatment methods and the length and type of their training. Considerable progress has been achieved in this respect but there are still enormous differences between the definitions of medical doctors and specialists in medical disciplines among countries.

In parallel, however with the effort to define what physicians are and what they should know medicine begun to experience a further change – a transformation from a profession into a trade. The language of trade invaded medicine. Instead of patients physicians are treating clients or consumers; case managers have replaced general practitioners (who became specialists of general medicine); administrators replaced medical doctors as directors of hospitals; insistence on effectiveness, efficacy and efficiency in the provision of care replaced the emphasis on compassion and the devotion to helping patients resolve problems in their lives. Health Maintenance Organizations (HMO) came into existence to ensure that medical interventions and services cost as little as possible: being for-profit agencies HMO's often introduced rules that saved money at the expense of those whose needs were greatest. Some of them excluded treatment of people with mental illness from their offer of services others imposed the obligations to consult certain medical practitioners who were, in their opinion, better at treating diseases cheaply (even if the outcome of treatment was somewhat less optimal. The consequences of this emphasis on economic success and conversion of medicine to a trade have been significant both in terms of the organization of health care services and in terms of loss of humane qualities in medical practice.

Changes of medical ethics

Helping a patient to continue living with a disease and maintaining the notion that a member of the society has the duty to live despite of misery, pain and disease were two undisputed tasks of medical doctors in all societies, for a long time. Recent times have seen a weakening of this obligation. In a number of countries the patients' right to decide whether they wish to continue living has gained more supporters raising uncertainty about the role of the doctor who might be invited to help the patient die. Some countries are considering legislation that will regulate matters but for the medical doctor the replacement of the duty to live by the right to die means a major change. There is no doubt about the fact that in the past physicians have on occasion helped a patient who suffered from an incurable disease and unbearable pain to end their lives: but this was a personal decision of doctors who decided to go against prevailing ethical rules because of their compassion with their patient.

Another change of medical ethics evolved from the changes in the relationship between doctors and patients. For many centuries patients were relying on their doctors and accepted their recommendations as obligations. With time patients learned more about diseases and doctors became more clearly aware of the limitations of their knowledge. Social roles of many members of the society – including the physicians - and the very structure of society have changed. Human rights became recognized in legislation and in social relationships. As a consequence the paternalistic relationship of the omniscient physician and the ignorant patient seeking help in distress started to be replaced by a relationship of collaboration in the treatment of disease and in righting ways of life.

While this change can be welcomed for many reasons it also presents a major ethical problem for the physicians who until recently felt responsible for their patients' lives and at present must allow patients to live in a manner that is likely to produce disease limiting their intervention to advice. It has become acceptable that a woman refuses to allow massive surgical interventions that might save her life by eliminating a cancer because she can not bear the idea of living with a major deformity that the operation might produce. In previous times a physician who did not manage to change such a decision would feel incompetent - and his colleagues would feel the same.

In many cultures the doctor's primary obligation was until recently to work with the family of the patient and with the patient. In a number of countries – particularly in Asia the term "voluntary admission" for treatment in a hospital was used if the head of the family brought the patient to hospital and requested treatment for him or her – regardless of what the patient said [3]. The family had

to decide whether they can keep the patient in hospital because the survival of children and of other members of the family might have been endangered by the amounts that had to be paid for the treatment of one of the members of the family. Medical practice in the industrialized countries of Europe and other continents made the loyalty of doctors to their patients a priority. In those countries family members now request the right to know about their family member's diagnosis and prognosis: in countries in which the family had the priority as the doctor's partner the process is going in the opposite direction – the patients requesting the right to decide who should be informed and involved in the process of their treatment. It is clear that both extreme positions – working only with the family to the exclusion of the patient and working only with the patient to the exclusion of the family are wrong: but change from one of these positions to another, more reasonable position, presents a major difficulty and ethical dilemma for doctors brought up in the tradition of their medical schools and culture.

Changes of goals of health systems

The notion that all diseases will be curable – born in the first half of the twentieth century when Prontosil, a sulphonamide was discovered and shown to be effective against certain bacteria flourished for several decades and probably reached its acme in the 1980's when the World Health Organization (WHO) proclaimed that its goal will be Health for All by the Year 2000. [4]. The slogan was attractive and spread around the globe. At the time when it was coined, an explanation of its meaning could have been that the WHO wishes to define health as a dimension of human existence that exists even in the presence of disease and that it expects that governments of all countries will do their best to promote health so that disease can be born and overcome more easily. There was no such explanation and in the two decades that brought the world to the year 2000 WHO officials increasingly often had to state that they never expected that all disease will vanish from the world and that what they actually meant was that health care services should be made available to all by the end of the second millennium of our era.

That achieving Health for All in fact meant the build-up of health services for all was a disappointing discovery. The increase of the strength of health services can reduce the prevalence of some diseases (provided that the services are run well) but it certainly can not deal with all of them. Although the increase of coverage by health services is a laudable goal it never comes close to the lofty goal of changing the meaning of health and disease in a manner commensurate with current scientific discoveries – which could be implied by the slogan and

which could have oriented the efforts of society concerning the welfare of its members to an achievable and useful new goal.

A more realistic assessment of the potential of health care systems must therefore mean that its efforts should be directed to the primary prevention of those diseases that are preventable by currently existing effective and inexpensive means and to the care of people that have diseases that can not be prevented or cured at present. For most diseases that are preventable the goal of primary prevention is achievable only if all of society actively participates in it and if the health care system functions as the initiator and advisor to efforts of other social sectors including social welfare, labour, agriculture, education, housing, sanitation and urban development agencies as well as many others. The major task that remains for the health care system after it has initiated the preventive programmes is to help people with diseases to live with them and find ways to have a life of quality despite of their presence. At present health care agents are not trained to do this well and will have to develop and apply new ways of working if they are to be truly useful. Providing medication is certainly an important part of care of chronic illness but it is a part that can be learned fairly easily: other elements of care for people with chronic mental or physical illness are more difficult to develop and apply.

With the reorientation of care towards giving even attention to the management of acute communicable diseases and to long term care of chronic disease it will be necessary to make other adjustments in action and attitudes of health care staff. Among those changes the most important is to accept that success of medical or social intervention should not be the removal or the cure of diseases but an improvement of quality of life of persons affected by a disease and their integration into the community even though they are suffering from their disease [5]. The search for an optimal outcome defined jointly by the patient and the physician might mean arresting active treatment although some of the symptoms remain present or using most of the resources to build-up a niche in society that will allow the patient to be a part of it rather than to pursue goals that from a strictly medical point of view might be more desirable. Sometimes this reorientation would require no more than the application of common sense in care arrangements – best exemplified in the years of effort and only gradual acceptance of the fact that the control of pain in a terminal state of cancer might be more important than the avoidance of the dependence on opiates that might result from their use In such cases.

Another change of recent origin – that could perhaps be seen as a positive consequence of the professionalization of the medicine – is the acceptance

of the need to think about the quality of life of health personnel and about the many negative consequences of its neglect. The epidemic of burn-out of health care personnel working in institutions for the chronically ill described in recent years is one such consequence that in turn has led to a lesser quality of care and poorer health states of people treated in those facilities. Other consequences include the flight of personnel from posts concerned with the provision of care to administrative and research positions in medicine and the departure of experienced and well qualified staff from the health system into other areas of work.

Obsolescence of strategies of medicine

While changes of medicine that were not expected and are not necessarily welcome abound some of the strategies that were formulated years ago resist change and still direct efforts in directions unlikely to lead to sufficient returns for the effort invested.

One such strategy is that of insistence on introducing community medicine. Community medicine was an ideal worth pursuing some fifty years ago. It was based on several premises including the notion that neighbours will have a relationship of mutual help, that the health care staff will be pleased or at least accept to work in an outpatient and community setting, that health staff will be better informed about the local and home conditions important for the treatment, recovery and rehabilitation of the patients and that the physical closeness of the health care workers and the population will ensure early recognition and intervention to maintain and promote health. All of these reasons were valid a few decades ago. Meanwhile, rapid urbanization has become characteristic of all and in particular of the developing countries. The communities in which neighbours know one another and have a trustful relationship of mutual help are becoming less and less numerous. Indices of social disorganization such as crime, vandalism, interpersonal violence, high rates of drug abuse appeared in many communities. Health staff is reluctant to work in community services partly because of dangers of work in disorganized settings and partly because working in a community setting proved to reduce chances for academic advances and promotion. The high rates of immigration have in many places changed communities to such a degree that community service staff feels lost, unable to deal with the foreign culture to which they have come without ever moving from the area. Although these facts are well known the health decision makers at central and at the peripheral level still insist that community care - as originally defined - should be the general paradigm of care and refuse to invest their resources into

the development of new strategies of care that will be more effective in the situations which are evolving in many parts of the world.

Another strategy whose original formulation has become obsolete is that of primary health care. The Alma Ata Primary Health Conference in the late seventies of the twentieth century formulated a series of recommendations and defined the principles of primary health care. The Alma Ata prescriptions were in their nature ethical, not practical: in part this was a consequence of the differences in the concepts of primary health care held by the countries assembled in Alma Ata. Countries were supposed to develop their health care systems basing them on the ethical principles enunciated in the Alma Ata report and declaration. Some tried to do so often taking proposals concerning the ethical requirements for a health care system as a guide in the building of their health system. Many other countries paid little attention to what their ministers of health officially accepted as the world's strategy for the development of health care. In both instances it soon became obvious that the development of health services depends on factors that surpass the spheres of health ministries. The societal changes described above exerted a powerful influence on the shape of the public health services. The role of the private sector, for example – not mentioned nor discussed in the Alma Ata report – became more and more important and influenced the provision of health care in many countries. Health care workers at the level of first contact increasingly dissatisfied with conditions of work and the absence of career prospects changed their profession or moved to towns. The barefoot doctor of China – hailed as the true answer to the provision of health care in rural areas vanished together with other symbols of the revolution. In many countries specialists moved to the level of primary contact reducing the sphere of useful action of the general health worker. The postgraduate education of the general practitioner created a new area of conflict – between the primary care specialists and the specialists working at primary care levels. The development of the two-speed-medicine – for the rich and for the poor dealt another blow to the structures envisaged in Alma Ata. All this was to be expected – in thirty years many things change and old strategies cease to be useful; what is worrisome is the insistence of many decision makers on the application of a strategy that needs a serious revision in order to remain as important in the new time in which we live as it was when it was formulated.

Changes in the processes of medical practice

Recent estimates indicate that the numbers of practitioners of alternative medicine in industrialized countries – from chiropractors and herbalists to magnetiz-

ers and doctors of homeopathy – are not only roughly the same as the numbers of medical practitioners trained in medical schools but began surpassing them. Formal traditional medical systems such as the Ayurveda and Unani or Chinese traditional medicine as well as for the practices of South American curanderos continue to be used On the whole alternative medicine is gaining popularity and in some countries already receives legal recognition. The question which the practitioners of modern medicine do not ask – perhaps because they would not like to hear the answer – is why this trend exists. Modern medicine has scientific evidence for the effectiveness of many of its treatment methods. It has sophisticated and excellently performing diagnostic machinery at its disposal. It has a standardized system of training that ensures that graduates of medical schools have mastered the art and science of medicine. Traditional and alternative medicine has none of this. Its procedures are consecrated by tradition but for most of them there is no scientific evidence of effectiveness. The methods of examination and diagnosis vary but by and large remain restricted to a conversation between healers and patients and to a small number of techniques of unproven value. The medications that are offered are not standardized and there is no formal testing of their effects or side-effects. Some of the treatment methods that they still use are in fact harmful – such as stopping convulsions of a person with epilepsy by bringing their feet to an open fire which often results in severe burns.

It is probable that there are two main reasons for this situation. The first is a growing dissatisfaction with the way in which medical practice is performed. Physicians increasingly rely on diagnostic apparatus and their relationship with patients has changed. They spend less time talking with them and their communication skills are poor. Even the best still see the provision of information as a priority and, on the whole, show little compassion. Practitioners of traditional and alternative medicine on the other hand place major emphasis on listening to patients and remain inclined to create a magical atmosphere rather than to spend time giving precise information about the disease and their interventions.

The second main reason for the growth of alternative medicine is probably the growth of the belief that there must be a treatment for all diseases – perhaps partly produced by the medical profession and constant reports of miraculous treatments and discoveries. This, together with the increasing purchasing power of the populations in many countries – including developing countries as well – makes people who are sick consult both medical doctors as well as practitioners of alternative medicine.

The widespread use of computers – particularly in industrialized countries – massively contributes to the increase of knowledge about diseases and their

treatment of most of those who consult medical services. The fact that patients know so much (and often their comprehension of what they have learned is not complete) changes the nature of the encounter with the doctor and affects the confidence that patients have in their physicians who are often unable to follow the developments of medicine as well as would be necessary in order to retain the upper hand in dealing with their knowledgeable patients. The growth of sales of Over-The-Counter (OTC) medications on the other hand indicates the patients' tendency to use what they have learned for self-medication. The role of pharmacists as advisors to the patients who use OTC medications is thus becoming a more prominent and often neglected factor influencing health states of the population.

The doctor-patient relationship is not the only area affected by delays in learning about news in medicine. The quality of care suffers from it as well and so does the cost effectiveness of the treatment. Medical knowledge progresses very fast and in part because of this the efforts to bring doctors up-to-date have been, by and large, unsuccessful. The obligatory collection of credits for continuing medical education (CME) has been introduced to deal with this problem, without too much success. Obtaining CME credits is often a formality. CME credits are offered by congresses with minimal control over attendance at the sessions, sometimes provided by organizations of doubtful competence. Obligatory (but passive) attendance at lectures and symposia does not work better and does little to keep physicians abreast of knowledge in their field. Self-learning, and regular reading of medical journals (many of which would be available by internet) is often impossible because of high workload and lack of access to appropriately prepared materials in the languages spoken by the practitioners. Sales forces of pharmaceutical companies are, worldwide, a major source of information about the progress of medicine: the knowledge that they transmit, however, is usually, at least, in part biased.

Changes of the targets of medicine

Medicine's main goal is to prevent or cure diseases. To do this well, practitioners of medicine must know a great deal about diseases, their causes, treatment and prognosis. The explosion of medical knowledge made this a difficult task. New facts that change the comprehension of illnesses emerge at a rapid rate. The globalization has not only affected trade: it also brought new knowledge about the form of diseases and their treatment in different cultures and different geographical areas. The massive migration within and across countries made this knowledge very important and useful in daily practice.

In addition however a number of new diseases have been discovered, for example the Bolivian haemorrhagic fever, the Keshan disease, the Marburg virus disease, the Lassa fever, Ebola and the Legionnaire's disease [6]. Fortunately, none of them has spread globally. Other diseases of apparently recent origin for which remedies are still being sought – HIV/AIDS, and the Acute Respiratory Syndrome (SARS) have led to increases of mortality and morbidity globally or in a number of countries.

This news is bad enough, but the message becomes worse when other areas of ignorance are explored. A number of diseases about which we knew a great deal have changed their nature and present new problems. The therapy resistance of tuberculosis is an often cited example but there are others, possibly worse examples. Some of them are what Professor Gruenberg called "failures of our successes". People with chronic mental disorders, for example, live longer and so do their parents. Persons with schizophrenia aged sixty or more might find themselves responsible not only for their own life but also for their parents enfeebled by age and suffering from a variety of illnesses. Co-morbidity – surviving in the presence of two or more diseases at the same time has become very frequent: it is estimated, for example, that people with depressive disorders will also suffer from cardiovascular illnesses and/or diabetes in 20 to 30% of all cases. People with schizophrenia also have physical illnesses of different types much more frequently than those who do not show signs of schizophrenia. In surveys of elderly people it is not unusual to find that they suffer from four or more diseases. Knowledge necessary for an appropriate treatment of people with co-morbid states is still insufficient and even what is known is not within the armamentarium of most of the practicing physicians.

Iatrogenic disorders also make an important contribution to the prevalence of morbid state or impairments in populations that have been reached by health care. Some of these disorders are consequences of imperfect medications, such as tardive dyskinesia; others are a consequence of excessive treatment zeal sometimes fired by the prospect of economic gain as for example the high incidence of hysterectomies without sufficient justification seen in some parts of the United States of America and elsewhere. Others still, are consequences of health workers' ignorance, treatment errors and insufficient aftercare. It is clear that the reduction of the incidence of iatrogenic disorders by improved education of health workers, safer treatments and quality control would go hand in hand with better care for all patients and should therefore be given much higher priority than it receives today.

It is also proposed that an important new target for medicine should be a better control of behaviour that can lead to high risk states for disease or dis-

eases. This might include education about healthy life style, the prevention of violence, self-reliance in early discovery of signs of disease and similar tasks. It is however improbable that medicine alone can achieve much in this respect. At a realistic level medicine can not be expected to do more than indicate what would need to be done in order to prevent disease. Numerous other social service sectors have to participate in such effort. Yet, even if this happens it must be clear to all concerned that it might take generations before some of the changes of behaviour that would be necessary occur and become a constituent part of part of culture.

Illnesses of the health system

The epidemic of burn-out syndromes that has struck the health care systems in many countries is one of the most serious menaces for the health of the population. The "burn-out" syndrome was first described in nursing staff working on oncological wards with high mortality rates. Since then it became obvious that it can be observed in severe or less severe forms in many other health care settings. Typically it strikes staff working in peripheral health care units, primary school teachers, and officials at the distal end of the administrative chain. It is a consequence of a career in which nothing much happens, in which one is not rewarded for excellent work nor punished for errors. The career prospects are usually bleak, the salary poor. Much of the work might be repetitive and those who do it have the feeling that they are forgotten by all higher up and that they are of no value to anyone. A variety of symptoms have been described as being characteristic of the syndrome – ranging from a variety of somatic complaints to irritability, depressive mood, excessive fatigue and loss of interest in matters related to work and to other areas of life.

Unfortunately while the burn-out syndrome is becoming more frequent health decision makers remain very reluctant to admit that the problem exists and avoid doing what would be necessary to remove it or prevent it. Sometimes the poor performance of a unit – for example a hospital for people with chronic diseases – is noticed and new staff are added to improve its functioning: this usually leads to very little improvement because of the contagious nature of burn-out that will soon become obvious in the poor performance of new staff who have come to improve the situation. Burn-out can be prevented or removed but this requires additional education of health care workers and their bosses as well as a number of structural changes of the system: the realization that this is so might be among the main reasons for the reticence of decision makers who want to avoid substantive reforms fearing that they might fail and cover them with blame.

A chronic problem of the health care systems particularly in poor countries is the "brain drain", the exodus of trained professionals into countries – or to institutions in the same country – where salaries are higher and life seems better. In recent years the brain drain has assumed new forms. While previously individuals who wanted to leave the country did so after they have found a position – by contacts with friend or by other means it has now become common to see governments recruit professionals of good quality from the poorer countries. The recruiting governments state that they will provide a decent employment and some security for those who come to their country: what they do not discuss is the harm that can be done to an emerging health system if the best of its leaders are lured away. The governments of the donor countries tolerate this happening knowing that the best way of keeping people at home will be the creation of conditions for their work and life that will be as attractive as the conditions to which the professionals migrate and that for the time being they are unable or not willing establish such conditions. Meanwhile, one could envisage numerous arrangements that could be formalized in agreements between governments that would help country that recruits and the donor country. Unfortunately this is not happening.

Globalisation has led to an imposition of value systems of the stronger countries to those less powerful. Some of these values have a direct impact on health care. Self-reliance in various areas of one's life, including the care for one's health has been a dominant theme in some of the developed countries, particularly those that have incorporated the ideas of protestant religions into their cultural heritage. In other countries self-reliance was not considered desirable: the member of the society did not strive for independence but felt that interdependence offers the best chances for survival and an enjoyable existence. In those countries disease or other miseries were shouldered together. The introduction of the idea of self-reliance goes against this arrangement and places the responsibility on the individual. Should individuals fail to look after themselves the responsibility falls on society as a whole, i.e. to the government that is supposed to represents it. For many, particularly the healthy and the strong in the country previously relying on interdependence the principle of self-reliance is attractive because it liberates them from the myriad of obligations that interdependency implies. Thus, they accept the notion and promote it. The problem resides in the fact that governments in countries in which the members of the population until now coped by relying on one another usually do not have the resources and perhaps not even the intention to help its citizens deal with their problems.

Another sin of many administrators and decision makers in the field of health is that they do not accept the notion that the burden of disease can be reduced by appropriate treatment and other measures but that it is not reduced by transferring the persons who are suffering from a disease to the responsibility of someone else. Thus, one of the tenets of modern health care is that patients should be treated at home (as soon as possible and for as much of the time in disease as possible) and that their family should look after them. This way of proceeding, decision makers say, reduces the cost of treatment and is much better for the patient. While a part of this argument is true – it is on the whole better to treat patients at home and to ensure that their family looks after them the second part of the argument is demagogical and untrue. The cost of treatment is not diminished by the treatment of patients at home: it is simply hidden by expecting the family or the patient to take on the costs themselves. In addition it is increasingly often difficult to expect that the majority of patients will have a family that has sufficient material resources and moral strength to look after a sick member and to continue living a normal life: in the current situation therefore treatment at home must go hand in hand with active and significant financial and other support from the health care system and social services. If these are not forthcoming discharging patients may well lead to a worsening of their condition and significant disruption of their families.

Coda

It seems reasonable to urge decision makers and ourselves to examine the prevailing strategies of health care and attempt to bring them into harmony with the developments and trends in society and the state of knowledge of medicine. Such an examination cannot be the exclusive province of health workers: it must involve, in an active manner, all the stakeholders in the field of health. Representatives of family and patient organizations, of governmental sectors other than health (for example the ministries of labour, education and the interior) and of the health industry should collaborate in this effort, with, if at all possible, the commitment to bring their activities in harmony with the findings of their joint examination of the situation. It is, however, neither reasonable to expect nor likely that the current strategies of health care can or should be completely revised: reforms and changes have a chance to be successful if they preserve the best parts of the previous system and marry them with innovations that will make it function better.

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Sažetak

Medicina u eri decivilizacije

U članku se govori o aktualnim trendovima u razvoju medicine. U prvom dijelu članka nabrojeni su i analizirani neki od najvažnijih društvenih trendova koji se odnose na medicinu. To su sljedeći procesi: decivilizacija (pad skrbi i pažnje što ih društvo pokazuje prema svojim ugroženim članovima), globalizacija, *artiklizacija* (tendencija da se zdravstvo, zdravstvena skrb i mnoge druge socijalne službe i usluge tretiraju poput robnih artikala kao što su šećer ili pamuk), decentralizacija socijalnih službi, promjene koje se tiču srednjeg društvenog sloja, tehnološka revolucija te posljedice migracija i populacijskih kretanja. U drugom dijelu članka riječ je o promjenama u medicini, promjenama unutar medicinske etike, izmijenjenim ciljevima zdravstvenih sustava, zastarjelim bitnim strategijama zdravstvene skrbi i promjenama unutar sustava zdravstvene skrbi. Ukratko se govori i o iscrpljivanju zdravstvenog osoblja te učinku uspostave novih vrijednosnih sustava pod utjecajem globalizacije. Na kraju članka ističe se potreba za preispitivanjem strategija zdravstvene skrbi uz uključivanje sviju angažiranih u području zdravstva: predstavnika obiteljskih i bolesničkih organizacija, ostalih vladinih sektora (npr. obrazovanje i rad), zdravstvene industrije i mnogih kategorija profesionalaca s područja medicine. Cilj je uskladiti te strategije s razvitkom društva u cjelini.

Ključne riječi: medicina; globalizacija; decivilizacija; medicinska etika; strategija zdravstvene skrbi.