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Social influence on medicine: An analysis and a proposal

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Abstract

This article addresses the influence of social factors on medicine. I describe a couple of relevant examples and argue that such influence can be both beneficial and harmful to medicine. I conclude by describing a values-based framework, the use of which may optimize the benefit-harm ratio of this influence.

Keywords: Benefit, Harm, Influence, Medicine, Social, Values

Current medicine is expected to develop in accordance with robust evidence that is generated by rigorous – such as controlled or otherwise comparative[1] – methodology. Yet medicine to date does not always follow such evidence. Indeed, medical knowledge and even more so practice and policy are influenced by other factors in addition to (biological) evidence, such as economic, cultural and other social factors (recognizing that psychosocial evidence can be robust too).[2] This may or may not be a problem; to decide whether it is a problem which should be addressed, consequences of such social influence have to be illustrated.

In this article I describe a couple of such examples from current medicine; I then argue that such influence can be both beneficial and harmful to medicine (and most importantly, to its end users – patients), and I conclude by describing a values-based framework, the use of which may optimize the benefit-harm ratio of this influence.

The first example of medicine not following evidence is related largely to knowledge and practice. Current psychiatry prioritizes neuroscience and biological interventions such as psychotropic medications relative to social science and psychosocial interventions such as psychotherapy and even more so psychiatric/psychosocial rehabilitation (PSR). [3]

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[1]Rudnick A. A philosophical analysis of the general methodology of qualitative research: a critical rationalist perspective. *Health Care Analysis* 2014;22(3):245-54.

[2]Freidson E. *Profession of medicine: a study of the sociology of applied knowledge*. Chicago (US): University of Chicago Press; 1988.

[3]Le Fanu J. The rise and fall of biological psychiatry. *Brain* 2014;137(6):1850-2.

This is in spite the fact that psychotherapy such as cognitive behavioral therapy (CBT) and PSR such as supported employment are evidence-based.[4,5]

Indeed, in my professional experience as a psychiatrist and a psychiatric rehabilitation practitioner in Canada and elsewhere, psychiatrists rarely practice PSR nor teach it to their medical trainees (ranging from undergraduates to postgraduates), which perpetuates this neglect; the argument that other mental health care providers deliver PSR and hence psychiatrists do not have to be involved with PSR is not convincing as PSR is not profession-specific, and as at the very least psychiatrists should be knowledgeable and preferably also at least minimally skilled in such a key set of practices in order to work to full scope as team members if not as solo practitioners.

A second example of medicine not following evidence is related largely to policy. Current medicine prioritizes hospital based care such as acute inpatient care relative to community based care such as primary care, as demonstrated by the fact that in Canada as in many if not most jurisdictions across the world more resources have been and still are provided to hospital based care than to community based care. This is in spite of the fact that community based care can prevent much hospital based care and increase access to health care; morbidity and mortality as well as cost may not be decreased, although quality of life is increased.[6]

Both examples suggest that community based care (which PSR and primary care principally focus on) is not a priority for current medicine, i.e., for medical knowledge, practice and policy. This could be related to the fact that in many jurisdictions, including in most if not all of Canada, physicians are compensated poorly for community based care relative to hospital based care. This explanation addresses economics; simply put, if funders pay more for hospital care, providers will deliver more hospital care. Another explanation may be that community based care requires more social science involvement, which is traditionally not considered to be a key part of medicine, although historically social science has contributed much to modern medicine's development.[7] This explanation addresses culture and politics of knowledge; this is a more complicated issue, as in order to understand why medicine has not formally endorsed social science as one of its key basic sciences, historical and other inquiry is needed, which I will not engage with here, other than to suggest that the notion of paradigms and their dominance – to the exclusion of other evidence-supported approaches – in knowledge professions may play a role in medicine as well as in science.[8]

The consequences of such economic, cultural and other social influences may be beneficial to medicine and its end users. This is so because medical knowledge and even more so practice and policy should be attuned to and preferably aligned with society's current and expected needs, constraints, and opportunities. Yet the consequences of such social influences may also be harmful to medicine. This is so because if medical knowledge excludes robust evidence, whatever its information source, it may not provide best guidance to practice and policy.

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[4]Dobson D, Dobson KS. *Evidence-based practice of cognitive-behavioral therapy, 2nd ed.* New York (US): Guilford Press; 2016.

[5]Corrigan PW. *Principles and practice of psychiatric rehabilitation: an empirical approach, 2nd ed*. New York (US): Guilford Press; 2016.

[6]Sibbald B, McDonald R, Roland M. Shifting care from hospitals to the community: a review of the evidence on quality and efficiency. *Journal of Health Services Research & Policy* 2007;12(2):110–7.

[7]Rudnick A, Forchuk C (eds). *Social science methods in health research*. New Delhi (India): Sage Publications; 2017.

[8]Kuhn TS. *The structure of scientific revolutions, 2nd ed.* Chicago (US): University of Chicago Press; 1970.

It seems that social influence on medicine is inevitable, and that knowledge by itself is not sufficient to strike an optimal benefit-harm ratio of this influence. Common values may provide guidance in this context. These general values are shared across societies and may be interpreted differently in each society.[9] Such common values are the set comprised of being person-centered, evidence-informed and socially responsible.[10] Each of these values involves components or aspects that can be weighted differently in different societies. For example, being person-centered may involve giving principal respect to individual decision making in contemporary North American culture and giving principal respect to family decision making in traditional Japanese culture. Being evidence-informed may involve giving principal weight to qualitative research in exploratory research and giving principal weight to quantitative research in confirmatory research. And being socially responsible may involve giving principal consideration to fiscal accountability in capitalist societies and giving principal consideration to moral accountability in social democratic societies.

Arguably, such a value-based approach can guide medical knowledge, practice and policy to be inclusive of multiple sources of information, so long as the evidence is robust, and to support practice and policy that are influenced by such rigorous pluralism as well as by social needs, constraints and opportunities. Further theoretical inquiry and related empirical research are needed to study the implications of this approach and to clarify its strengths and weaknesses.

[9]Macklin R. Against relativism: cultural diversity and the search for ethical universals in medicine. Oxford (UK): Oxford University Press; 1999.

[10]Rudnick A. Principled physician (and other health care) leadership: introducing a value-based approach. *Canadian Journal of Physician Leadership* 2014;1(1):7-10.

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