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ESSENTIALS It is the job of doctors to know about disease and how to diagnose and treat it, and textbooks such as this are part of that endeavour. However, proportionally little actual physical disease remains in resource-rich countries of today, yet the demand is for more and more medicine. This prompts the conclusion that other forces determine the demand for contemporary healthcare. A counterculture view of the traditional medical model is offered here in which the reasons why patients consult their doctors is explored. In countries with developed healthcare, the traditional medical model of illness is dead or at least dying. A simplistic and reductionist approach to medicine is insufficient and signally fails to recognize or integrate the complexities of illness behaviour, and why it is that patients seek medical advice today. Contrary to traditional thinking and teaching, it is not illness that dictates the health-seeking behaviour of a population but the healthcare system itself, and—most importantly—our actions as healthcare professionals. A scourge affecting clinical practice in the developed world today is the medicalization of all interactions, accompanied by overinvestigation, overdiagnosis, and overtreatment. Our profession retains its traditional duty, wherever possible, to diagnose disease and treat or cure illness appropriately, also to comfort the sick, irrespective of the ability to cure. At the same time, a long-held principle of medicine at all levels is to do no harm, while at the same time supporting the maintenance of health and protecting those who are well. Maintaining the balance between these apparent conflicting precepts is a scarce skill that needs to be taught by example during the education and training of the modern doctor.

Introduction In the traditional 'medical model' we assume that the reason for the consultation is self-evident: patients have symptoms, a history is taken, an examination is conducted, and the diagnosis is made—treatment is then offered. It is a process perfected by countless generations of doctors through the ages: concrete, familiar, and certain. Knowledge of clinical signs and symptoms is the foundation of our professional status and the basis of the professional fees charged. But the concrete is beginning to crumble. Clinical

knowledge is no longer the preserve of the profession; anyone with a smart (mobile) phone can access global medical knowledge in a matter of seconds. In a lifetime, illness has changed out of recognition. In the developed world there is no rheumatic fever or diphtheria and finally with the introduction of new vaccines, even bacterial meningitis is being eradicated. Infectious disease as we know it, the great scourge of humanity a century ago, has gone. Tuberculosis is still present but occurs principally in recent immigrants. Similarly, we are witnessing the end of smoking-related conditions with premature ischaemic heart disease and stroke rapidly disappearing, and lung cancer in decline. For other common cancers we offer screening programmes that detect cancers long before they become symptomatic and drive the traditional medical consultation (screening is discussed later). In resource-rich countries of today, proportionally little actual physical disease remains. Predicted health spending should fall but in reality health costs are burgeoning: figures from the World Bank show that in the United States almost one in every five dollars is consumed by healthcare and figures published by the US Center for Disease Control in 2014 provide compelling evidence for this trend. This prompts the conclusion that other forces determine the costs of contemporary healthcare as it is provided as well as utilized. A counterculture view of the traditional medical model is offered here in which the reasons why patients consult their doctors is explored. Importance of clinical communication Communication skills are often maligned as 'soft skills'; indeed, the old idea of 'bedside manner' is a pejorative term representing a mode of practise seen as increasingly irrelevant to the gleaming scientific new world of medicine. But the art and craft of communicating with patients in the new world of disappearing diseases is far more powerful than any machine or investigation. If we truly seek to establish 'why' the patient has consulted us, we need to listen and converse.

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1.4 Why do patients attend and what do they want from the consultation? 15 Every time a person, or a parent or guardian calls, and takes time out of their day to do so—often after an unconscionable wait and an even more punishing internal debate—they always have a specific reason. This reason—the so-called 'patient agenda'—is frequently overlooked, even though its crucial importance is a fundamental principle which applies across all healthcare settings. The traditional mechanistic approach, a tick list of questions, frequently fails since the 'agenda', either through fear or simple embarrassment, is so often 'hidden'. It is worth reflecting on own experiences as a patient: Did the doctor really discover what our concerns were? A simplistic guide which helps us to elicit this agenda is not a 'tick box' exercise, rather it is a more general and analytical way to understand the person who has become a patient by exploring their ideas, concerns, and expectations. Ask the patient if they have any 'idea' what might be causing their symptoms, what 'concerns' they might have about the symptoms, and what 'expectations' they have of the consultation. This may appear obvious, but doctors constantly and spectacularly fail to explore these aspects of their patients' motivation. Among many other disadvantages, this failure leads to overinvestigation, unnecessary referral and, ultimately, dissatisfaction. If we were to supplement the clinical approach with improved nonverbal communication which notes eye contact, posture, and facial expression, the chances of establishing why the patient has attended and of addressing what they seek from the consultation would be greatly enhanced. Development of skilful communication is important in life generally, but it is a crucial part of clinical education and clearly best reinforced by instruction and self-critical evaluation throughout one's entire professional career. Health beliefs We all have health beliefs. These may not be based on commonly accepted scientific precepts, but often defy scientific reasoning despite being held with

absolute conviction. Many patients (and some doctors) for example, passionately believe in homeopathy—this, despite the counterintuitive nature of the science (in homeopathy the more dilute a treatment, the stronger it is alleged to become). We may berate these ideas, but for the patient the effectiveness of homeopathy is a fixed ‘health belief’ held in the face of accepted scientific concepts and evidence. Strong health beliefs concern the benefit of other alternative medicines and medical interventions such as chiropractice, osteopathy, acupuncture, Reiki, and many others—despite little or no obvious scientific basis for their clinical use. As with many believers in matters requiring a large element of faith and trust, a challenge to these beliefs is frequently met by anger and defensiveness. However, it is not just those who pursue alternative treatment who have unscientific health beliefs. Does removing tonsils reduce the rates of sore throat? Do annual physician examinations offer any value to health? Do screening programmes cause more harm than good? Indeed, individual doctors strongly disagree over much of the foundation of what may be termed medical science. A fascinating aspect of health beliefs is that they seem to be inherited, passed down through the family. If your parents have certain health beliefs, you are likely to share them. For example, patients who attend doctors frequently often belong to family clusters. In one study conducted by the author, members of families classified as frequent attenders constituted about 10% of the population but accounted for 50% of consultations.

Health culture Consider what shapes and influences health beliefs that differ radically between people and populations. Why should otherwise apparently similar populations have wide variation in consultation rates across the world? How can health costs vary about twofold between countries such as the United Kingdom and the United States? In the United Kingdom most doctors are salaried and are not generally paid according to their activity. In most systems, however, ‘fee for service’ is payable. This remunerates doctors for activity and encourages more testing, more prescribing, and more consumption of healthcare. The simple truth is that many doctors consciously or subconsciously have vested financial interests in ensuring that patients return for care, even for minor illness. A cynical view would be that many have a vested financial interest in rendering patients doctor-dependent and health-anxious. Making those who are well, worried, can certainly be a great business model. Doctors often blame patients for needless health-seeking behaviour, but in truth, doctors and their medical health systems forge this health culture. The wide variation in health-seeking behaviour between different nationalities owes much to the health system that operates in the countries of origin.

Changing health beliefs An important principle to reduce health-seeking behaviour is based on the concept of Numbers Needed Not to Treat—the number of patients we need not to treat, to prevent one patient returning with the next episode of illness. Intervene more, and more patients will return: intervene less and less patients return. So health systems should seek to intervene less. A simple illustration is the use of antibiotics for sore throat. Declining to prescribe antibiotics might lead initially to conflict with patients. In time, however, as shown by Little and colleagues in a study involving nearly 800 patients from 11 primary care centres of general practice in the United Kingdom, the patients will realize that they will not be prescribed an antibiotic, and will appreciate the natural course of many types of sore throat, which improve without this treatment. Their health belief changes and gratuitous attendance decreases. This is better clinical practice and frees up access, thus reducing pressure on the medical system. While the complications of sore throat may not be rare and can be severe (with some requiring intravenous antibiotic treatment, management of fluid balance, and sometimes surgical intervention due to lack of treatment or inadequate antimicrobial therapy), correctly applied, the principle offers a way to reduce demand in all healthcare services. Changing the clinical practice of doctors, changes the behaviour of patients. This facile idea is one that is

beyond the comprehension of many with responsibility for healthcare. We must not conflate more medicine as better medicine: generally less medicine is better medicine.

16 SECTION 1 Patients and their treatment The i-patient effect Two doctors working in the same healthcare system, same area, and serving patients with similar demographic characteristics can vary their referral rates—in a recent study by the author—by as much as 10-fold, with highly divergent investigations and prescribing patterns. How can this be explained? Like all of us, doctors are hostage to their own health beliefs: those who take antibiotics for coughs and colds will duly dispense antibiotics to patients for similar indications. Doctors anxious about their own cardiovascular health will prescribe more statins and antihypertensive drugs. Doctors worried about their own pigmented lesions will refer patients with skin lesions more frequently. Simply put: doctors' personal beliefs affect their clinical practice. This is what I and others have termed the 'i-patient' effect. Doctors who are anxious and who struggle with uncertainty and risk, practise very differently from the those who do not. We cannot prevent doctors bringing their individual health bias into the consulting room, but understanding and acknowledging our own health beliefs allows us to control its influence. While this may appear to be an obvious concept, it is one that is scarcely acknowledged and little studied. One might ask whether there is an argument that universities should select medical students who have low personal anxiety about their own health anxiety.

Medical reviews—the problem of 'bring backs' How often do patients need to be invited to return for review? Every week, every month, every year, or perhaps never. Intervals recommended for medical 'check-ups' have a limited scientific basis and are frequently found to be a mere thoughtless habit. It is appropriate to reflect on how much time is dedicated to reviewing appointments for raised cholesterol, hypertension, routine blood tests and the remaining justifications for such 'bring backs'. In most systems of healthcare, these review appointments are highly lucrative activities driven simply by financial interest. But in systems with limited budgets, access for the sick is restricted because of this factor. Many medical systems are busy, often with numerous pointless, unscientific but easy recall appointments, rather than busy serving the sick. The so-called 'inverse care law' dictates that most healthcare is consumed by those least at risk, rather than those with the most medical need. In financial terms, 'contact time' with medical professionals represents the greatest expenditure, yet many healthcare systems appear to be devoid of any reflection on how this costly resource is used. Simply changing the interval between reviews would free up numerous appointments, but this important aspect of healthcare practice has attracted very little attention for research.

Particular difficult issues Medically unexplained symptoms The medical model has a familiar simplicity that is accessible to doctors, but the classic description of disease is unravelling in developed countries because many diseases are themselves in terminal decline. The patterns and frequency of vascular or infectious diseases are changing rapidly, some cancers are in decline, and there is even an end in sight for smoking-related disease. Patients now more frequently present with nebulous symptoms such as tiredness, weakness, numbness, dizziness, headaches, bladder symptoms and, most commonly, unexplained or bizarre forms of pain. Such patients are often the majority of those attending primary care and in several hospital settings. Clearly, because such symptoms could represent a more serious condition, those who complain of them generate a whirlwind of uncertainty in doctors weaned on the traditional medical model. This uncertainty precipitates testing and the prescription of medications. These patients are the frequent attenders: they accumulate thick medical files and report persistent, and ever-changing patterns of symptoms which constitute a chronic illness. Despite endless investigations these symptoms remain 'medically unexplained': this term is not

used here to dismiss these patients, because their symptoms are real to them, but there is no underlying pathological process. Estimates indicate that a quarter of consultations are for unexplained symptoms, but experience suggests that in reality the proportion might be even higher. So, medically unexplained symptoms should hold a priority position in every medical textbook (see Chapter 26.3.3), and this author contends that every medical school should have an academic group devoted to their study, although clearly this is not the case. Current medical teaching usually suggests that symptoms equate to the presence pathology, and accordingly many doctors are simply unable to recognize patients with symptoms that will defy understanding in straightforward pathological terms. Doctors should reassure these patients, and their failure to do so is the cause of ever-increasing use of investigations, polypharmacy (most notably analgesics and psychoactive agents), interventions, and hospital admissions, thereby employing vast resources. In the United States, the epidemic of deaths from the use of prescription drugs is in part caused by the fact that pain has been treated as a simple symptom, and not a subjective, complex, and often medically unexplained process. Moreover, in a private healthcare system, patients presenting with medically unexplained symptoms are at a particular risk of being exploited cynically for profit. As our insights into many medically unexplained symptoms are not likely to be rapidly enhanced by innovative research, we would do well to consider the views of a few wise physicians, often with experience in primary care, that while this may not be the science of medicine, it more accurately reflects the art of medicine. Some of these views are epitomized in the following cautionary statements, some of which may appear cynical or might prove to be inappropriate in individual cases: 'If the symptoms don't make any sense then there is nothing wrong with them.' 'Remember, frequency of attendance is inversely proportional to likelihood of pathology.' 'Referring the anxious only makes them more anxious.' 'Medicine is just magic and misdirection.' 'Everything you were taught in medical school is wrong.' 'Look for normality, not pathology.' 'Do nothing, but with style.'

1.4 Why do patients attend and what do they want from the consultation? 17 The sick role and conversion syndromes Many forces encourage patients to attend a doctor, but sometimes we should remember that there may be a personal gain from being 'sick'. There is a range of illness behaviours: at its most basic, it can generate a spontaneous day off work, the 'sickie'; but more destructive behaviour can be seen in which the patient appears completely wheel-chair bound. The sick role affords attention, sympathy, and even status within family and society. The role can excuse us from work and responsibility, and may be rewarded with financial benefits. Such patients typically complain of medically unexplained symptoms and often have no insight into their illness behaviour. It is not as simple as 'just pretending' but much more complex: family members, either consciously or subconsciously, often collude in maintaining this sick role by acting as advocates. In addition, extreme sickness behaviour can be expressed through a proxy, such as a child or older person, who is offered up as having an illness which is fabricated: 'Munchausen disease by proxy'. Tackling extreme sickness behaviour is very challenging, if not impossible, for doctors: patients and families alike can become very hostile and angry at any suggestion that symptoms might be psychologically based. Doctors need to be taught and made aware of the extremes of sickness behaviour. Drug-seeking and manipulative behaviours Doctors have replaced the gruff paternalism of the past with 'patient-centredness': we are encouraged to use expressions like 'choice', 'patient power', and to adopt a 'nonjudgemental' stance. This is a seismic shift in the doctor-patient relationship. Today, it is hard to say 'no' to the patient; indeed, even challenging patients' views or requests for particular treatment is difficult in our complaint-driven

culture, hence a form of consumerism is the new norm of medicine. However, giving patients what they 'want' can lead to very bad medicine, which is harmful to the recipient. Sometimes patients wilfully seek to deceive doctors—a statement that is not cynicism but realism, and perhaps best illustrated by those seeking psychoactive medications, such as opioids, benzodiazepines, and the antiemetic, cyclizine; more recently gabapentin and related drugs are implicated. Patients can either sell these medications or personally abuse them (often both) in what is overt deception. Often pain or anxiety symptoms are reported at the time of presentation. Doctors accept this history in good faith and prescribe psychoactive medication. Soon there are stories of mislaid or lost medications and dose escalation. In countries where healthcare is poorly integrated, patients may go 'doctor shopping', attending multiple doctors from each of whom they are independently prescribed medication. Active deceit of this kind is signalled by inconsistent accounts and aggressive or tearful reactions to any form of challenge. Lack of ability to address or recognize manipulative behaviour is in part responsible for the epidemic of drug-related deaths in North America. The Centers for Disease control report data from the National Vital Statistics System 2013 that in the United States, 44 people die every day from overdose of prescription opioid painkillers, and many more become addicted. More than twice as many residents die annually from unintended prescription drug overdoses than the total number of US soldiers killed in Iraq. Drug-seeking places a huge pressure on practising doctors. Trust in medicine has great power to heal; but mistrust and manipulation of medicine exerts a huge power and harm. Welfare benefits In many countries, doctors act as gatekeepers to welfare benefits. If you could receive more income would there not be a strong incentive to overplay and invent symptoms? Many people cheat on claims for expenses or seek to minimize or avoid income tax, and so there are well-known parallel behaviours. Some would ask, if you were injured in a road traffic accident, where is the harm in overstating your neck pain to improve your pay out? There are huge variations in reported sickness rates across countries and regions that simply cannot be accounted for by illness prevalence, and it is a statement of fact that patients will attend doctors seeking to manipulate insurance and benefit systems. External forces There are, of course, the individual reasons why patients attend doctors. However, other major environmental forces are in play, which constantly effect health-seeking behaviour and health beliefs. These are not always predictable and are often beyond intervention and thus largely outside the remit of medical control. Medical charities and advocacy groups Patient advocacy groups and charities are considered to be important and legitimate to healthcare. Charities also offer important photo opportunities for politicians and are a constant source of human-interest stories for the media; they have real grass roots support. So charities sponsor campaigns advertising disease awareness that encourage patients to seek medical advice. But we should ask the question: Is the role of charities always positive? Advocacy pressure groups can dominate agendas, potentially distorting resource allocation. Health messages promulgated by charities are often in effect simplistic sound bites that are factually flawed and couched in emotionally charged language. Often, despite there being a lack of evidence of benefit, they call for more screening, testing, and treatment. There are nefarious interests at work, too. Charities are sometimes exploited by the corporate medicine and pharmaceutical companies in an activity colloquially known as, 'astroturfing'. In this activity, companies provide large sums of money to charities, who unwittingly act as proxy advocates of these companies. For a charity, promoting a disease is also promoting the treatment, and this might be one of several competing medications. Not cynicism, but again merely good business sense. It is always worth exploring the reported sources of funding of medical charities, for the distorting effect of corporate money is widespread. Direct-to-consumer advertising There has been an explosion of prescribing in the last

few decades, such that today lifelong polypharmacy is the norm and not the exception. Coprescription of several drug classes is frequent, including statins, antihypertensives, bisphosphonates, antidiabetic agents, nonsteroidal analgesics, opioids, proton-pump inhibitors, and ever-mushrooming mental health medication. For 'chronic disease' is the golden goose that provides most of the revenue for Big

18 SECTION 1 Patients and their treatment Pharma. So how better to promote your medication (sometimes for dubious conditions, especially in relation to sexual 'performance' in women and men) than directly to patients? In the United States (one of only two countries to allow public advertising), flashing logos, tear-jerking stories, and smiling celebrities paid to offer personal endorsements (e.g. a famous sportsman in the promotion of sildenafil) fill the airways. For example, in 2011 it was reported that one company (Pfizer) had spent \$220 million on advertising its top-selling cholesterol drug in the previous year, which was almost 25% of its overall \$900 million in direct-to-consumer (DTC) spending. And as the internet is poorly regulated, companies are advertising the world over: after all, who knows who is behind online blogs and medical forums. There seems to be little we can do to resist the power of marketing and advertising. The patient is reduced to the status of a health 'consumer' (where the customer is always right), thus disturbing the equilibrium in the doctor-patient relationship forever. Money shapes the reason and outcome of our consultations, and it is a telling fact that despite competition in the free market of the United States, not only the charges for branded drugs are up to twice those in other countries, but the expenditure per capita is the highest of any country.

Internal forces Paid experts and 'disease creep' Despite the essentially egalitarian nature of science and scientific enquiry, medicine remains a deeply hierarchical and deferential profession. The professional medical agenda is set by a few international specialists and opinion leaders, often cultivated by companies and referred to as KOLs, or key opinion leaders. Small groups of specialists define conditions, control guidelines, and sit on national governmental advisory boards. An example of the influence is provided by national recommendations which change the boundaries of treatment for raised serum cholesterol concentrations, thus encircling ever more people who become patients receiving lifelong treatment. It has been suggested that 25% of people in the United States have a 'mental illness', a simply incredible figure which reflects a pervasive 'disease creep' observed in numerous definitions and conditions. This softening and blurring of boundaries has the effect of ensnaring people into the world of unmet medical needs. Defining the 'unmet medical need' is a critical point for meaningful interactions. Despite a strong backlash and the recent Sunshine Act in the United States, with tight controls in Europe, some medical opinion leaders are still found to be on the take, and over past years, some have been paid very large sums of money by pharmaceutical companies to work as their paid advisers and advocates. It is an uncomfortable truth that everywhere in the world there are undisclosed payments to practising doctors. Indeed, in relation to the generous figures for mental illness cited earlier, the author noted in 2012 that about three-quarters of the contributors to the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association report conflicts of interest and links to pharmaceutical corporations. Other countries are belatedly introducing Sunshine legislation which forces companies and doctors to disclose payments and links, but in many ways this has been too little and too late. Evidence-based medicine In the mid-1990s, evidence-based medicine arrived to save medicine from the vagaries of opinion and bring 'best clinical evidence' to the care of the individual patient. Naturally, the explicit articulation of the previously arcane process of therapeutic decision-making was a

source of wide-ranging reflection and has undoubtedly rid medicine of much poor practice. But evidence-based medicine has itself become a shackle, a vehicle of judgement, a new source of deference, and spurious virtue. Where rigorous evidence is unobtainable or simply lacking, the approach has replaced the deferential behaviour and unquestioned practices of the past with another parody of the Emperor with no clothes. Emperors were tyrants and so doctors mutter: 'better not go against the evidence'. Thus, clinical care is increasing proscriptive, and 'clinical guidelines' have become an instrument of pervasive political control. The problem is much of the evidence is not what it seems. There is an inherent commissioning bias, for pharmaceutical companies own and commission most of the available 'evidence'. Thus the evidence-based agenda is dominated by a commercial therapeutic mindset. Also the available research is riven with surrogate end points which are required by regulatory authorities for licensing and approval of drugs for reimbursement. Often these have been arrived at and agreed in the absence of a true clinical perspective of the disease as experienced by patients and seen by their doctors: achieving the predetermined outcomes with endpoints that maybe statistically significant is of little use if the outcomes are clinically irrelevant. Moreover, research data from high-risk populations often recruited into clinical trials are usually wide off the mark but sometimes cynically extrapolated to patients with low risk present in unselected general populations. Unfortunately, the temptation to cheat, and opportunities for cheating in research are legion. In research involving clinical trials, there are incentives to err because there are literally billions of dollars to be made. One US researcher faked research leading to billion-dollar sales. Research fraud related to pharmaceutical activity and clinical trials remains even now an important matter. Corrupt researchers affiliated to the pharmaceutical industry face little by way of punishment other than the indirect reputational damage cast onto their employing organization. The importance of good clinical practice and rigorous monitoring of clinical trial results should not be overemphasized. Evidence-based medicine has become the principal marketing tool of the pharmaceutical industry: naturally, this is a scientifically persuasive and appropriate stance, but it requires ceaseless vigilance to ensure that those who engage in evidence-laundering to sell their medication are in a tiny minority and that they are punished rigorously for misdemeanours. Screening Medical screening consumes increasing amounts of professional effort, especially in primary care. The intuitive principle is extremely attractive at first glance: catch a condition early and the better the outcome—or so it appears. Thus, even questioning the value of screening generates angry defensiveness. But the issues at stake are not simple. Detecting a condition earlier may merely mean you know about a cancer earlier, rather than live longer. Also, detecting cancer early might give an artificial appearance of better outcome, if the outcome is determined by the '5-year survival'. This is known as

1.4 Why do patients attend and what do they want from the consultation? 19 'lead time bias' and confounds attempts to compare survival statistics between countries. However, the major issue for all screening is the effect of 'overdiagnosis'. Cancer screening programmes provide illustrative examples. They may often identify tiny nonprogressive tumours, as a result of which we witness a rapid increase in cancer prevalence, such as has been noted in melanoma, breast, and bowel cancers. Since the detection by screening includes nonprogressive cancers, screening tends to produce a better relative overall survival rate but, depending on the type of tumour screened for, the change in absolute death rate is often very limited. There is then an epidemiologic pattern of overdiagnosis generated by screening. Screening is often hailed as the equivalent of Mao's Great Leap Forward for Medicine, and while it may lead to absolute benefit in terms of health, such benefits tend to be less than expected. Moreover, they must be balanced against the certain costs

of real harm: it is highly disingenuous to trumpet clinical success if millions of people are 'diagnosed' with a cancer that is not progressive but who then undergo unnecessary chemotherapy and surgery with consequential loss of well-being and independence. How not to harm the healthy is a sophisticated challenge for the authentic success of many contemporary, and superficially attractive, screening programmes. The need for change Given that the traditional medical model of illness is moribund, the scope, as well as style of medical education must adapt at all levels. The current reductionist approach to medicine classically fails to recognize or integrate the complexities of illness behaviour and often ignores the factors which drive patients to seek medical advice. It is now clear that it is not illness that dictates the health-seeking behaviour of a population but the healthcare system itself, and importantly the actions of healthcare professionals. A key principle of medicine, that the most important intervention is non-intervention, is linked strongly to the notion that our most potent medicine is reassurance. If, through enlightened teaching and research, we were able to enhance understanding of why patients attend health services, then we might be able to at least contain the burgeoning scourge of contemporary medicine: medicalization. Medicalization of all clinical interactions leads to overinvestigation, overdiagnosis, and overtreatment. Our profession retains its traditional duty, wherever possible, to diagnose disease and treat or cure illness appropriately, also to comfort the sick, irrespective of the ability to cure. At the same time, a long-held principle of medicine at all levels is to do no harm, while at the same time supporting the maintenance of health and protecting those who are well. Maintaining the balance between these apparent conflicting precepts is a scarce skill that needs to be taught by example during the education and training of the modern doctor.

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