

Health lag: medical philosophy reflects on COVID-19 pandemic

Alireza Monajemi¹, Hamidreza Namazi^{2*}

1. Assistant Professor, Department of Philosophy of Science and Technology, Institute for Humanities and Cultural Studies, Tehran, Iran.

2. Assistant Professor, Department of Medical Ethics, School of Medicine, Tehran University of Medical Sciences, Tehran, Iran.

Abstract

In this paper, we reflect on the COVID-19 pandemic based on medical philosophy. A critical examination of the Corona crisis uncovers that in order to understand and explain the unpreparedness of the health systems, we need a new conceptual framework. This helps us to look at this phenomenon in a new way, address new problems, and come up with creative solutions. Our proposal is that “health lag” is a concept that could help frame and explain this unpreparedness and unreadiness. The term “health lag” refers to the failure of health systems to keep up with clinical medicine. In other words, health issues in most situations fall behind clinical medicine, leading to social, cultural, and economic problems. In the first step to define health lag, we have to explain the distinction between clinical medicine and health and address the role of individual health, public health, and epidemic in this dichotomy. Thereafter, the reasons behind health lag will be analyzed in three levels: theoretical, practical, and institutional. In the third step, we will point out the most important consequences of health lag: the medicalization of health, the inconsistency of biopolitics, inadequate ethical frameworks, and public sphere vulnerabilities. Finally, we try to come up with a set of recommendations based on this philosophical-conceptual analysis.

Keywords: Medical philosophy; Medical humanities; Medicalization; Public health; COVID-19; Pandemics.

*Corresponding Author

Hamidreza Namazi

No. 21, Medical Ethics and History of Medicine Research Center, 16 Azar St., Tehran, Iran.

Tel: (+98) 21 66 41 96 61

Email: hnamazi@tums.ac.ir

Received: 1 Nov 2020

Accepted: 30 Nov 2020

Published: 23 Dec 2020

Citation to this article:

Monajemi A, Namazi H. Health lag: medical philosophy reflects on COVID-19 pandemic. *J Med Ethics Hist Med.* 2020; 13(Suppl.): 28.

Introduction

Bill Gates, in a Ted Talk in 2015, compared the cold war situation with the present time. He told a story about when he was a kid, the American people were worried about nuclear war. All families had filled their cellars with cans of food and water. All people were taught what was needed to be done in a crisis: go downstairs, hunker down, and eat out of the barrel. However, nowadays, rather than a nuclear war, the greatest risk is pandemic. But it seems that we are not actually well prepared for such an epidemic (1). Furthermore, the comparison between the COVID-19 pandemic and the Spanish flu that happened a hundred years ago reveals that the preventive technology (e.g., mask) has not changed significantly, and we use roughly the same measures against COVID-19. In this period of time, however, the diagnostic and therapeutic technologies have evolved so drastically that previous technologies look as old as the hills. Why is that? Why prevention has remained unchanged in the past hundred years, while the diagnosis and treatment have improved drastically? Why we are never ready for epidemics?

In addition to the existing healthcare crises, the latest coronavirus pandemic has exposed several challenges in the healthcare systems around the world, such as system inability to rapidly detect and monitor the dissemination of the novel coronavirus, late adoption of physical-distancing protocols, contradictory and delayed national guidelines on handling the pandemic, inadequate leadership and

excessive partisanship, governmental health management, distrust of the government, lack of national public health information system, poor communication between governments, health professionals, biomedical scientists, the media and the public sphere, and poor health media literacy. It is no exaggeration to say that because of the under-developed and under-resourced public health system, the response of the public health system to the COVID-19 pandemic is not effective (2,3). It is currently recommended that for controlling the corona crisis the whole-government and whole-society should be involved; however, this shows the inadequacy and inefficiency of the health system (4).

In this paper, the authors reflect on the COVID-19 pandemic based on medical philosophy. A critical examination of the Corona crisis reveals that in order to understand and explain the unpreparedness of the health system, a new conceptual framework is needed. This helps us to look at the phenomena in a new way, address new problems, and come up with creative solutions. Our proposal is that “health lag” is the concept that could explain the current unpreparedness and unreadiness. So, first, we define health lag, for which purpose we have to distinct clinical medicine from health and address the role of health, public health, and epidemic in this dichotomy. Thereafter, the reasons behind health lag will be analyzed in three levels: theoretical, practical, and institutional. We then will point out the most important consequences of health lag: the

medicalization of the health, the inconsistency of biopolitics, inadequate ethical frameworks, and public sphere vulnerabilities. Finally, we try to come up with a set of recommendations based on this philosophical-conceptual analysis.

The Health versus the Clinical medicine

What is “health lag”? The term “health lag” refers to the failure of the health system to keep up with clinical medicine advancements. In other words, health issues in most situations fall behind clinical medicine that leads to or causes social, cultural, and economic problems. Health lag occurs due to unequal and undivided attention to health issues rather than medical issues. It demonstrates itself at theoretical, practical, and institutional levels, creating a gap between the material and non-material culture (5).

To formulate the problem, firstly the health and the clinic are compared. Prevention is linked with health, while diagnosis-treatment is linked with clinical medicine. Health is more related to the community, whereas clinical medicine is correlated to the hospital. The health practice is focused on maintenance and preservation, while clinical medicine aims to bring back the healthy situation. In other words, the health is related to preservation and the clinic is related to restoration. The health is more concerned with the community, i.e., and non-medical aspects such as culture and economics, while the clinic is more about the individuals.

The distinction between individual health and public health lies in clinical medicine. Clinical medicine focuses on individual health, and what is left out of the medical field is related to public health. On the contrary, in the health context, individual health and public health are intertwined; in other words, individual health affects public health and vice versa. Health practices (e.g. health preservation) consider both individual and public health. Clinical medicine has the necessary components such as theoretical knowledge, practice, and related institution, while it seems that these components in healthcare have received little attention.

An epidemic, an event that highlights the gap between individual and public health, cannot be managed only by reducing it to the clinical situation. An epidemic indicates that a specific disease has occurred at a specific time and place beyond expectations. Contrary to health in which individual and public matters, public diseases do not make sense. However, the epidemic confronts us with situations in which the disease is spread in the population and therefore we need to understand the social, cultural, and political dimensions of health. This has always been neglected. The inability to control the epidemic is due to health lag rather than their insufficient clinical knowledge or inadequate clinical system.

The unpreparedness of the health (theory, practice, and institution)

The health lag is basically due to the

enigmatic nature of health. "Health is often unnoticed and sustains its proper balance and proportion" (6). Gadamer suggests that humans cannot understand health if everything is right. The basic meaning of health emerges and develops, only when a disease has occurred (7). Consequently, the disease is the object of positive sciences and is considered a statistical abnormality. As a result, health has converted or transformed into "normality" that is directly defined in statistics. However, the statistical interpretation of normality is not value-free and is used as a mechanism of power and control when transformed into normativity (8). Another aspect of the value-lateness of the health is that people are influenced by health conceptions of the society where they live, and how others try to cope with illnesses (9).

This ontological situation indicates health-related theory, practice, and institution. Theoretically, practically, and institutionally, public health sciences lag behind the medical sciences.

Goraya and Scambler (10) have shown that public health has undergone successive transformations over the years: sanitary (1840-1870), preventative (1870-1940), and therapeutic phase (1940 -1970).

In response to the industrial revolution and the associated poverty as well as the living condition of the metropolitan workers (e.g. overcrowded and insanitary), the sanitary phase started. The preventive phase began around 1870 when the appropriate public

health interventions were redefined based on the germ theory of disease. As a result, public health physicians relinquished authority to deal with all aspects of environmental sanitation (e.g. housing and poverty). The emphasis switched from the public to the individual. Personal preventive services (e.g. family planning and immunization) and individual health education were raised subsequently. Despite the remarkable success of vaccines, infectious diseases were still not effectively treated until the 1940s. The discovery of antibiotics put forward the concept of the 'magic bullet'. Paradoxically, public health physicians, who were expected to investigate the social and cultural determinants of health and to plan services accordingly, became administrators of medical interventions.

The transformations in the public health conception could explain why health sciences have dissociated from public health problems, theories, and practices. Epidemiology proclaims itself the foundation of public health; however, rather than focusing on the research applications, it has been preoccupied with the design and methodology of research. Furthermore, the gap between public health sciences and practices is widening as the design and implementation of interventions in social and political contexts inevitably create tensions. Ill-structured health institutions are the main reasons behind this gap (11).

The Consequences of health lag

Health lag has several consequences, the

most prominent ones are: medicalization of health, inconsistency of the biopolitics concepts, and inadequate health ethics frameworks. This highlights the huge impact of health lag on the fields outside medicine.

Medicalization of health

Medicalization refers to the expansion of medicine outside its borders. The causes of medicalization are different. For example, escaping from problems and the inability to face the ups and downs of life are among the reasons behind the success of medicalization in society. Health is a governmental affair in most countries around the world, and therefore, unlike medicine, it is less commercially successful. It also seems that more attention is paid to health research when it is designed and conducted in a medical context. After all, health is political, and medicalization can depoliticize it, making it scientific and socially acceptable. Therefore, health always needs an integrated strategy. This strategy is the same as what is used for medicine. The medicalization of the health, on the one hand, negatively affects the preventive nature of health and that leads to neglecting the care (12).

Compared to other health concepts, health care is a misleading concept. This is because healthcare defines issues based on individual diagnosis and treatment strategies. A network consists of medical professionals, industries, technologies, and pharmaceuticals, medicalize health problems. Medicalization has neglected the necessary social, community, or political

actions, shifting public health issues towards looking for medical and technical solutions (13).

Public health, on the contrary to individual health, is based on the concept of population and epidemiology and is more objective. Replacing the concept of health with normality is due to the fact that in the age of technoscience, mobilizing public opinion, changing policies and attitudes, and allocating research funding requires scientificization and technicalization (14).

Inconsistency of biopolitics

Health lag indicates that health is not simply limited to clinical medicine and has cultural, social, and political aspects. Although “medicalization of health” depoliticizes it, it makes managing events such as epidemics difficult and complicated. Experts in epidemiology and other health sciences as well as clinical specialists try to provide solutions to the pandemic macro-control policy. However, since they considered the medical institution-society relationship as the doctor-patient relationship and sought community compliance rather than the social, cultural and political, aspects of health, the controlling measures have remained ineffective. In other words, they see the socio-cultural aspects of health as obstacles to overcome to control the epidemic. Politicians, on the other hand, understand health as clinical medicine but listen to expert advice as long as it does not interfere with socio-political concerns.

Biopolitics links health with clinical issues (15). This does not mean biopolitics that aims at eugenesis, nor does it seek social control, but it is a concept close to *care-politics*. Since health is described as a governmental duty and a right for the citizens, care policy does not mean governmental stewardship but requires everyone to take care of their own health as well as that of others.

Inadequate health ethics frameworks

Commonly, medical ethics applies to the doctor-patient relationship, while the interactions between an agency or institution and a community or population are the focus of public health ethics. Medical ethics is based on four principles (i.e., autonomy, non-maleficence, beneficence, and justice), while justice, interdependence, community trust, and fundamentality are the central issues of public health ethics. As public health is intertwined with social, cultural, and political issues, medical ethics is incapable of dealing with public health plans and interventions (16).

The three mistakes in moral reasoning in the COVID-19 pandemic highlight the other aspects of health ethics inadequacy: “illusion that we can avoid trade-offs,” “leave it to the experts”, and “precautionary paradox” (17).

Public sphere vulnerabilities

As health is not based on an independent theory and knowledge, popularization of health leads to medical language usage. Using medical vocabulary and literature to encourage people to preserve health will lead to health anxiety. This is because we have to

look for possible diseases in ourselves to make sure that we are healthy. This requires a visit to the doctor and one to the laboratory and medical imaging. Examples of effective health internships can be seen in established health institutions.

The meaning of ‘health’ is of central importance to the orientation of public health activities. If ‘health’ is equated with the absence of disease, as it is in epidemiology, more emphasis will be shifted towards disease prevention. If it is interpreted in a broader sense, more stress will be on involving the equitable distribution of the health foundations and health promotion. If public health theory and practice are quite distinct from the individualistic approach to health, the conception of public health will be based on a strong commitment to collective endeavor (18).

Conclusion

The most recent use of the term ‘new public health’ has emerged from the recognition of the fact that major health problems cannot be solved by current medical care (18). For epidemiology to become reintegrated with public health practices, changes will be required in both the education and training of epidemiologists as well as in the practice of public health. It will not be easy for epidemiology to regain its population purposes and have a closer connection with healthy public policies. In this regard, a social policy approach to healthy lifestyles’ rather than the current ‘lifestyle approach to social

policy' is required (18).

In order to overcome health lag, medical humanities should play a crucial role both in reflecting on the health lag and criticizing the contemporary approach to health. In this regard, a paradigm shift towards critical medical humanities should take place (15). Interdisciplinary disciplines such as health policy, bioethics, and medical education that originally belong to the field of medical humanities¹ have forgotten their roots and become highly technicalized and bureaucratized.

Will discovering the corona vaccine solve all the problems?

Do we no longer need to deal with health lag? Would science reclaim its superiority with the discovery of the vaccine? Is it true to say that the main reason behind the priority of clinical medicine over health is greater efficiency and less complexity? Would these questions still be relevant in the presence of the vaccine? Should the vaccine be given to everyone? If not, who is in priority? Obviously, these are not the main clinical concerns. So, it could be concluded that there is no escape from prioritization, which is a philosophical, political, social, and cultural issue and belongs to the health realm.

1 . Medical Humanities is a field of research, education, and practice that examines health and medical issues from the perspective of medical philosophy, medical ethics, medical hermeneutics, medical sociology, medical history, literature and medicine, and so on. Medical humanities, while trying to neutralize and overcome the reductive and dehumanizing approach of biomedicine, has attempted to improve and enrich clinical practice, patient care, and medical education (5).

References

1. Gates B. The next outbreak? We 're not ready. [cited 2020 December]; available from: https://www.ted.com/talks/bill_gates_the_next_outbreak_we_re_not_ready/transcript?language=en
2. Blumenthal D, Fowler EJ, Abrams M, Collins SR. COVID-19 implications for the health care system. *N Engl J Med*. 2020; 383(15): 1483-8.
3. Wang H, Cleary PD, Little J, Auffray C. Communicating in a public health crisis. *The Lancet Digital Health*. 2020; 2(10): E503. DOI: [https://doi.org/10.1016/S2589-7500\(20\)30197-7](https://doi.org/10.1016/S2589-7500(20)30197-7)
4. Raofi A, Takian A, Akbari Sari A, Olyaeemanesh A, Haghighi H, Aarabi M. COVID-19 pandemic and comparative health policy learning in Iran. *Arch Iran Med*. 2020; 23(4): 220–34.
5. Monajemi A, Namazi H. Medical humanities meets corona virus pandemic: a report of the webinar on the dialogue between medicine and humanities. *International Journal of Body, Mind and Culture*. 2020; 7(1): 44-7.
6. Gadamer HG. *The Enigma of Health: The Art of Healing in a Scientific Age*, 1st ed. USA: Stanford University Press; 1996, p.103-17.
7. Svenaeus F. *The Hermeneutics of Medicine and the Phenomenology of Health: Steps Towards a Philosophy of Medical Practice*, 1st ed. USA: Springer; 2000, p. 78-94.
8. Foucault M. *The Birth of the Clinic*. UK: Routledge; 2012, p 39-41.
9. Chadwick R. Normality as convention and as scientific fact. In: Schramme S, Edwards E, eds. *Handbook of the Philosophy of Medicine*, 1st ed. Netherlands: Springer; 2017, p. 17- 28.
10. Goraya A, Scambler G. 'From old to new public health: role tensions and contradictions'. *Critical Public Health*. 1998; 8(2): 141–51.
11. Bhopal R. *Concepts of Epidemiology: Integrating the Ideas, Theories, Principles, and Methods of Epidemiology*, 3rd ed. UK: Oxford University Press; 2016, p. 389-425.
12. Contino G. The Medicalization of health and shared responsibility. *New Bioeth*. 2016; 22(1): 45-55.
13. Clark J. Medicalization of global health 1: has the global health agenda become too medicalized? *Glob Health Action*. 2014; 7: 10.3402/gha.v7.23998.
14. Monajemi A. Clinical practice in the techno-science age: living in crisis. *International Journal of Body, Mind & Culture*. 2018; 5(2): 84-8.
15. Atkinson S, Evans B, Woods A, Kearns R. 'The Medical' and 'Health' in a critical medical humanity. *J Med Humanit*. 2015; 36(1): 71- 81.
16. Swain GR, Burns, KA, Etkind P. Preparedness: medical ethics versus public health ethics. *Journal of Public Health Management and Practice*. 2008; 14(4): 354-57.
17. Stefánsson HO. Three mistakes in the moral reasoning about the COVID-19 pandemic. [cited 2020 December]; available from: <https://www.iffs.se/en/publications/working-papers/three-mistakes-in-the-moral-reasoning-about-the-covid-19-pandemic/>
18. Beaglehole R. *Public Health at the Crossroads (Achievements and Prospects)*, 2nd ed. UK: Cambridge University Press; 2004, p. 250-84..