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Physicians and Iatrogenism From The Philosophy of Medicine to The Sociology of Health

Tıbbın Felsefesinden Sağlığın Sosyolojisine Hekimler ve İatrojenizm

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Abstract: In pre-modern times, health services provided by traditional healers such as clergymen, healers, and herbalists were conducted by professionalss specialized in modern medicine such as physicians and auxiliary health personnel. Although modern Western medicine has developed in many areas, it has been criticized severely. The most important of these criticisms is the unquestionable structure of modern medicine and the methods and techniques used by physicians in the treatment processes in connection with this structure. These criticisms are termed with the concept of iatrogenesis, and criticisms against both modern medicine and physicians are becoming sharper. The aim of this study is to question and analyze the issue of iatrogenism, which has caused important debates in medical sciences and social sciences, in the context of the apparatuses of the modern medical system and especially the profession of medicine. Therefore, in this study, the forms of iatrogenesis produced by modern medicine in general and by physicians in particular will be discussed from the perspective of medical philosophy and health sociology. The scope of the study is limited to the relationship between physicians and iatrogenism in the context of issues such as patient-physician relations, the commercialization of health services, the construction of the patient as a customer, the pharmaceutical industry and guided scientific studies, excessive use of drugs and medical devices, the medicalization of life, and the popularity of traditional treatment methods.

Keywords. Health sociology, Philosophy of medicine, The profession of medicine, Iatrogenesis, Modern medicine.

Öz: Modern öncesi dönemlerde, din adamları, şifacılar, otacılar gibi geleneksel iyileştiriciler olarak adlandırılan kişilerin yürüttüğü sağlık hizmetleri, modern dönemle birlikte hekimler, yardımcı sağlık personelleri gibi modern tıp alanında uzmanlaşmış sağlık aktörleri ya da meslekler tarafından icra edilmeye başlanmıştır. Ancak geçmişten bugüne modern Batı tıbbı birçok alanda gelişme göstermesine rağmen son dönemlerde önemli eleştiriler almaktadır. Bu eleştirilerin başında ise modern tıbbın sorgulanamaz yapısı ve bu yapıyla bağlantılı olarak hekimlerin tedavi süreçlerinde kullandığı yöntem ve teknikler gelmektedir. Bu eleştiriler iatrojenez kavramıyla tahkim edilmekte ve gerek modern tıbba gerekse de hekimlere yönelik eleştiriler daha da keskinleşmektedir. Bu çalışmanın amacı tıp bilimlerinde ve sosyal bilimler alanında önemli tartışmalara neden olan iatrojenizm meselesini, modern tıp sisteminin aygıtları ve özellikle de hekimlik mesleği bağlamında sorgulamak ve analiz etmektir. Dolayısıyla bu çalışmada tıp felsefesi ve sağlık sosyolojisi perspektiflerinden hareketle genel olarak modern tıbbın özelde ise hekimlerin ürettiği iatrojenez biçimlerine değinilecektir. Çalışmanın kapsamı, özellikle

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son dönemlerde tartışılan, hasta-hekim ilişkileri, sağlık hizmetlerinin ticarileşmesi, hastanın bir müşteri olarak inşa edilmesi, ilaç endüstrisi ve güdümlü bilimsel çalışmalar, aşırı ilaç ve tıbbi cihaz kullanımı, yaşamın tıbbileştirilmesi, geleneksel tedavi yöntemlerinin popülerlik kazanması gibi konular bağlamında hekimler ve iatrojenizm ilişkisiyle sınırlıdır.

Anahtar Kelimeler: Sağlık sosyolojisi, Tıp felsefesi, Hekimlik, İatrojenez, Modern tıp.

Introductıon

There is an ancient interplay between medicine and philosophy. Although the history of studies on the philosophy of medicine can be traced back to recent times, the origins of these studies are as old as the history of medicine. It is known that there has been a rich conceptual and intellectual heritage about discoveries in the field of medicine, reasoning in medicine and the development process of medical knowledge since Greek philosophy and science. Therefore, as an ancient field of discussion, the philosophy of medicine has reached a rich literature based on the insights and texts of many traditional and contemporary thinkers such as Plato, Aristotle, Galen, Hippocrates, Ibn Sina, Farabi, Ibn Hindu, Er-Razi, Descartes, Kant, Hegel, Foucault, Turner (Ulukütük, 2018: 168). The fact that this ancient heritage between medicine and philosophy has come to be remembered again in recent times undoubtedly carries a different motivation. This motivation takes its references from the radical criticisms made against the philosophy of the modern medical approach, which has been dominant around the world for nearly two centuries, which is shaped around key concepts such as human, patient, physician, body, cosmos, ethics and culture. Because modern medicine, with the power provided by positivist science, the legitimacy gained from Cartesian philosophy and the superiority provided by technical power with the tools, has eliminated traditional medicine and constructed the body as an object to be intervened. Descartes' Cartesian philosophy, which is the basis of modern medicine, separated the body and the soul and transformed the body image into a machine that could be repaired by an engineer in the perspective of the principles of geometry and mechanics (Illich, 2017: 109).

Radical criticisms of positivism in scientific circles since the 1950s have brought about, on the one hand, the formation of post-modern approaches, and, on the other hand, a reckoning with positivism in the natural and social sciences. However, the field of medicine has postponed its reckoning with positivism for some time. One of the most important reasons delaying this reckoning is the over-specialization produced by the positivist paradigm. The physician, who works in this over-specialized medical system, constructs the patient as a biological mechanism that has been broken into pieces, rather than positioning her within a humane and cultural system (Önal, 2007: 146-147). The fact that modern medicine avoids confronting positivism and insists on excessive specialization has also ensured the continuity of the authority established by medicine. Because, as Foucault (2002: 59) points out, modern medicine, with the power it derived from this authority, had now far exceeded the limits required by the techniques of treatment and the body of knowledge of diseases. Because medicine was in the position of the actor that determined both the knowledge of healthy people, the examination of non-sick people, and the definition of model people. Medicine adopted a normative attitude that assumed the right to dictate the individual's life, physical and moral relationships within the standards of society.

The medical system, regardless of the way it obtains information, needs a philosophy to decide where, when, and why to use this information (Önal, 2007: 146). In other words, the field and knowledge of medicine have been seen as one of the problematics of philosophy for a long time. For example, philosophy shaped science and thought in Ancient Greece; physicians such as Alkmaion, Empedocles, Hippocrates, and Galenus were also among the great philosophers of their time. Hippocrates, one of these physician-philosophers, emphasized that philosophy should be included in medicine and medicine should be included in philosophy, and also stated that a physician can be glorified if he is also a philosopher. Galenus also emphasized that the virtuous physician must also be a philosopher (Ulukutük, 2018: 170). In addition, Galenus argued that philosophy should be mandatory for physicians in order to provide the theoretical basis that medicine needs. According to Galenus, the physician should not only be a practical healer (empirical), but also have knowledge of logic (the art of thinking), physics (natural

science) and ethics (rules of behavior). Because according to Galenus, a healer without a philosopher was like a builder doing haphazard work. The real physician, on the other hand, should be like an architect with proper plans (Porter, 2016: 46).

The holistic understanding of medicine and philosophy is also found in the thought system of Muslim philosophers. The word "wisdom" plays a key role in this understanding. The word "hikmet", which is also used in Turkish, is derived from the Arabic root "hakeme", and the verb "hakeme" means to prohibit, forbid, detain, restrain, keep, and order in order to improve anything. In addition to its many meanings, the concept of wisdom is also defined as a moral philosophy that keeps people away from all kinds of bad feelings, emotions, thoughts, and actions that are not worthy of their honor and dignity (Önal, 2007: 148). Fazlur-Rahman (1997: 126) states that the concept of "hikme", which means wisdom, describes both philosophy and medicine, and that the concept of "hukema", derived from the word "hikmet", means both physicians and philosophers. On the other hand, according to Yakıt (2015: 23), who states that there is a unity of meaning between the words "hikmet" and "hekim", the word "hekim" is a lightened pronunciation of the word "hakim" and has the same meaning. The physician is the one who prevents ignorance and wrongdoing. In other words, judges are physicians and physicians are judges. Because according to traditional thought, the laws of the universe at the macro level were also the laws of the human body at the micro level. Since the philosophers, the judges, had knowledge of the universe, they also had knowledge of the human body. Therefore, the word "physician" has been given a more specific meaning and given the semantic meaning of "one who prevents disease". From this perspective, a physician is someone who has the knowledge to prevent disease.

Although there are not many discussions on the relationship between medicine and philosophy or the basic problems of the philosophy of medicine in the literature, there are some studies both in Turkish and foreign literature. In this context, the following studies can be mentioned: Elisha Bartlett's work, “Essay on the Philosophy of Medical Science”, one of the first works written in the field of philosophy of medicine in Western literatüre; William Stempsey's articles, “Philosophy of Medicine: The Development of a Discipline” and “Philosophy of Medicine is What Medical Philosophers Do”; Arthur Caplan's article, “Does The Philosophy of Medicine Exist?”; Edmund Pellegrino's article, “What the philosophy of medicine is”; Ali Haydar Bayat's book, “Tıp Tarihi”; Dimitri Gutas's work, “İbn Sina Devrinde Tıp Teorisi ve Bilimsel Metod”; Hatice Toksöz's article, “İbn Sina’ya Göre Tıp-Felsefe İlişkisi Bağlamında İnsanın Maddi Yapısı”; M. Cüneyt Kaya's articles, “Tabipler için Felsefe: İbn Hindû’nun Felsefe Tasavvuru ve Sözlüğü” and “Tabibin Felsefeye İhtiyacı Var mı? İbn Hindû’ya Göre Tıp-Felsefe İlişkisi ”; Hayrullah Diker's book, “Felsefe-i Tıb”; Renê Leriche's work, “Philosophy of Shirurgy”; Serhat Soyşekerci's book, “Beden Sanatı Rembrandt ve Anatomi Dersleri”; Mehmet Önal’s article, “İslam Hikmet Anlayışına Dayalı Bir Tıp Felsefesi Önerisi”; Şahin Efil’s works, “Din-Sağlık İlişkisinin İmkanı Sorunu Din Felsefesine Mütevazı Bir Katkı” and “Modern Tıpta Ölümsüzlük Arayışı ve Eleştirisi”; M. Bilgin Saydam and Hakan Kızıltan's edition, “Hekimin Filozof Hali” and Murat Tura’s article, “Tıp Niçin Felsefeye Gereksinim Duyar?” (Ulukütük, 2018: 170-182). These studies have undoubtedly made significant contributions to the development of the field of philosophy of medicine. However, when we look at the literature, there are no studies that deal with the iatrogenic dimension of the medical profession in the context of philosophy of medicine.

Edmund Pellegrino, in his article *What the philosophy of medicine is*, states that there are four basic problems addressed in discussions on the philosophy of medicine. These problems are as follows (cited in Ulukütük, 2018: 181).

- Philosophy of medicine as a dialog between medicine and philosophy
- Philosophy of medicine as the reflections of philosophical disciplines in medicine and their application to medicine
- Medical philosophy as a reflection of clinical wisdom in physicians
- Philosophy of medicine as a discipline that deals with issues such as human health, illness, disease, discomfort, death, and the desire for a healthy life.

Many studies have been carried out within these four basic problem areas and from the perspective of different disciplines. Many issues such as the macro-philosophical insights behind the philosopher-physicians' understanding of medicine, the philosophical origins of medical practices, and the philosophical criticism of contemporary understandings of health and illness have been studied in the context of the philosophy of medicine. However, the fact that the relationship between physicians and iatrogenism has not been sufficiently addressed in the context of philosophy of medicine constitutes the weakness of philosophy of medicine studies. Therefore, this study focuses on the iatrogenic reflections of clinical wisdom in physicians, which is one of the main areas of debate in the philosophy of medicine. In line with these limitations, this study does not attempt a comprehensive discussion of other areas of the philosophy of medicine. In this sense, in order to provide a perspective to the study, the thoughts of some philosopher-physicians mentioned in the field of philosophy of medicine are included at a limited level. In short, this study aims to discuss the neglected iatrogenic dimension of the physician and the neglected iatrogenic dimension of medicine, which is discussed in various aspects in the field of philosophy of medicine, and thus to contribute to the philosophy of medicine literature. On this occasion, it would be appropriate to mention the following point: This study is not written with the motivation of "discrediting" modern medicine, physicians, the medical profession, or health care personnel, but rather with the motivation of developing a coping strategy for the "iatrogenic identity" that has been embedded in the structure of these medical understanding and professions over time. Undoubtedly, as the iatrogenist identity within the modern medical system is traced through such studies, the criticism of medicine and physicians, which has been responded to by society as a bottom wave, will be minimized.

The Iatrogenesis Identity of Modern Medicine

Health is an institution that fulfills the basic social needs of people from past to present and is closely related to social institutions such as family, education, economy, politics, and religion. Moreover, due to factors such as industrialization, urbanization, technical developments in the field of medicine, and the increase in epidemics, health has turned into a system in which almost every form of organization has developed a discourse since the 1900s. Modern medicine has declared its sovereignty as the "magic concept" of this system.

Modern medicine has developed many diagnostic and therapeutic methods that were not possible a century ago, such as imaging all tissues and organs of the body, significant progress in pharmacology, tissue, organ and face transplants, and robotic surgeries. Despite its advances in many fields, modern Western medicine is still criticized severely. At the forefront of these criticisms is the unquestionable structure of modern medicine and, in connection with this structure, the methods and techniques used by physicians in treatment processes. When these criticisms are termed with the concept of iatrogenesis, criticisms against modern medicine and physicians can become more radical.

Ivan Illich, who systematized the concept of iatrogenesis and brought it into the sociology of health literature, argues in his book *Limits to Medicine - Medical Nemesis: The Expropriation of Health* that medicine does more harm than good to patients with useless treatments, worsens the conditions that make society unhealthy instead of improving them and takes away the freedom of individuals to heal themselves, suffer or die. According to Illich, "the medical establishment has become a great danger to health. The effect of professional domination in medicine has reached epidemic proportions. The origin of Iatrogenesis, the name of this new epidemic, is formed from the classical Greek words iatros, meaning 'physician', and genesis, meaning 'origin'" (2017: 11). According to Illich, who explains the harms caused by the physician (iatrogenesis) in three ways: clinical, social, and cultural-symbolic iatrogenesis, all sectors of the industry in today's world are growing significantly on the one hand, while causing irreparable harm on the other. This damage can be expressed through the concept of iatrogenesis in the field of medicine:

- If pain, illness, and death are caused by medical services, this is called "clinical iatrogenesis".
- If current health policies support industrial entities that produce ill-health, in other words, if medicine harms an individual's health because of a socio-political mode of transmission, this is called "social iatrogenesis".

- If the behaviors and beliefs supported by medicine limit people's vital freedoms by hindering their ability to develop, support each other and age, or if medical interventions disrupt the settings of people's personal responses to pain, helplessness, illness, and death, this situation can be defined by the concepts of "cultural and symbolic iatrogenesis" (Illich, 2017: 38, 196).

When modern medicine detects a disease in an individual, it intervenes the patient's life, changing his/her status and sometimes his/her entire way of life. This is because iatrogenesis is seen at every stage of medical care, thus becoming a part of medical care. In fact, the real problem is not to deal with its occurrence or prevention, but its definition and minimization (Kane, 1978: 2). This is because one of the definitions of diseases resulting from iatrogenesis states that the number of deaths and non-fatal hospitalizations directly attributable to medical intervention equals or exceeds the average number of deaths and non-fatal casualties resulting from the Korean or Vietnam wars (Kane, 1978: 1). Therefore, at this point today, the essential functions attributed to medicine, such as "healing" or "curing", need to be reconsidered.

Robert L. Kane, an American academic and physician who pioneered the discipline of gerontology with his work in geriatrics, published *Iatrogenesis: Just What The Doctor Ordered*. Two years after Ivan Illich published *Medical Nemesis*, Kane, like Illich, was radically critical of modern medicine. As a scientist from the field, Kane tried to fill in the boundaries of Illich's framework by addressing iatrogenism from a physician-centered perspective. In this study, Kane mentioned four forms of iatrogenesis:

- The first form of iatrogenesis is the "conscious risk factor", defined as the physician's choice of a method that carries some risk in most diagnostic and therapeutic decisions and that this risk is present in every surgical procedure and in the use of most medications.
- The second form of iatrogenism is the "unexpected complications factor", which refers to the occurrence of complications even when the physician provides care according to the best-known techniques. Examples of this form of iatrogenesis include the formation of bulges or bubbles in arteries and aortic vessels when the abdominal cavity is opened (laparotomy) for diagnostic or operative purposes, or the occurrence of previously unknown long-term side effects of medication.
- The third form of iatrogenesis is the "incompetent care factor". Examples of this form of iatrogenesis include misjudgments and misinterpretations by physicians or other health care providers that may adversely alter the course of the disease, lack of skill, inadequate knowledge, or superficial attention leading to major damage. In addition, misdiagnosis, inappropriate treatment, inadequate and negligent nursing care, and referral to miracle drugs are also considered as incompetent care.
- The fourth form of iatrogenesis is the "overzealous care factor". Overzealous care refers to the desire by physicians or other health professionals integrated into the health industry to treat patients to the point of addiction by causing them to feel unwarranted and unnecessary anxiety or worry about their illness. This is because the excessive anxiety created in patients can cause physical as well as mental damage. On the other hand, this situation can also lead to "economic disabilities". Because in the treatment of the disease, although a less costly and effective treatment method is possible, making the patient prefer expensive methods causes the patient to spend unnecessary money, causing poverty. Keane expresses concern that poverty may soon become a side effect of medical care. In addition, high-cost examinations, personalized medicines, the use of "miracle drugs", unnecessary surgeries and "over-diagnostic" tests, which are considered an overuse of medical resources, are examples of overzealous care (Kane, 1978: 2-3).

The issue of iatrogenesis, which Kane categorizes as conscious risk, unexpected complications, incompetent care, and overzealous care, is essentially a categorization of the criticisms voiced by many who are still harmed by modern medicine nearly half a century ago.

Modern medicine has a strong hold on today's health and disease systems. This is because conditions or disorders that cannot be defined in medical terms are ignored by modern medicine, and the patient's individual desires, wishes, or decisions are not given due attention. In addition, this understanding considers anyone who goes beyond modern medicine as going beyond science and rejects it (Elmacı, 2013: 59). This power that modern medicine has built has made it unquestionable and led to the establishment of a "church of science". However, this unquestionability certainly does not mean that modern medicine cannot be infallible.

The questioning of the iatrogenesis identity of modern medicine has led some physicians to search for new approaches. Acupuncture, the revival of Hippocratic-Galenic medicine, the increasing trend in the use of medicinal plants as medicine, and the criticisms of thinkers such as Ivan Illich who oppose the established modern medical philosophy have brought people to reconsider their relationship with health (Nasr, 2006: 191). In addition, the acceptance of traditional medical practices, which were rejected by modern medicine, has also increased the tendency towards traditional medicine. In the past, traditional medicine was sometimes belittled by practitioners of modern medicine and it was stated that it did not have any health benefits. Recently, however, a number of traditional treatments or procedures have begun to be seen as positive practices by Western medicine.

According to Ivan Illich, the French Revolution had an important place in the spread of the phenomenon of iatrogenesis. Illich (2017: 113) emphasizes two major myths that the French Revolution gave birth to in the establishment of iatrogenesis. The first was the myth that physicians could replace the clergy. With this myth, society delegated to physicians the privileged right to determine what is or is not a disease, who is or could be sick, and what kind of treatment should be applied to these people (Illich, 2017: 14). The period we live in has repeatedly staged the substitution of physicians for clergymen by turning it into an "absolute reality" (Turner, 2011: 80; Foucault, 2002). The second was the myth that society could regain its original health with political changes.

The myth that physicians can replace the clergy is no longer a myth but has become the reality of society. This reality continues the reign of iatrogenesis from the etiology of diseases to their classification. So much so that this iatrogenesis has reached such dimensions that it can also establish social organization on the basis of diseases (Foucault, 2002). According to Illich (2017: 123), the classification of diseases (nosology) in every society also reflects social organization. The diseases produced by society are baptized by the doctor by calling for the help of conceptualizations valued by bureaucrats. "Learning disability", "hyperkinesia", or "minimal brain dysfunction" become magical concepts with which parents try to explain to their children why they cannot learn, ignoring the inadequacy of education. In addition, hypertension (high blood pressure) is presented as an excuse for increased stress in social life and degenerative disease is an excuse for degenerated social organization. The physician is therefore the determinant of a healthy life and at the same time the lawmaker of modern medicine.

The second great myth that the French Revolution gave birth to was that "society can regain its original health through political changes". Undoubtedly, societies have been undergoing major political changes for nearly three centuries. At that time, many of the discourses of freedom, which were unleashed by the revolution, were stripped of their talisman tuned to the fire of the revolution and have turned into a sadness that makes these freedoms captive today. However, the second great myth of the revolution is also a reflection of social reality today. Because for the last three centuries, physical health has been able to provide the means to live longer. As Illich points out, diseases such as polio, diphtheria, pneumonia, syphilis, and tuberculosis, which once caused mass deaths in Western societies, were brought under control with the production of antibiotic drugs. Today, more than half of all deaths are caused by so-called diseases of old age (2017: 21). Therefore, the myth that societies will regain their original health through political changes has also been subjected to the sanctions of medicine's iatrogenesis identity. In this process, modern medicine has started to lose its credibility with its practices developed on the axis of biomedical theory, its medicalization of life at the maximum level, its practices that turn human health into a commercial commodity, and the knowledge it has transformed into power.

Modern medicine has also "medicalized" a number of processes that were traditionally regarded as stages of natural biological development. (Tekin, 2016: 96-97). "Medicalization", as conceptualized by S. Nettleton, describes the fact that certain processes such as aging, childbirth, child behavior, etc. are now under the control and study of medical experts. In this respect, medicalization corresponds to Illich's classification of cultural-symbolic iatrogenesis. While women's fertility is perceived as an ordinary and natural part of their life course in traditional life formats, with the technology-supported medical understanding of modern medicine, the process from the detection of pregnancy to the realization of birth is almost constructed as a "disease" (Senturk, 2008: 221). Medicalization can be defined as "medicine medicalizing areas that were not previously considered medical and expanding the scope of medicine to include these areas by claiming to be an expert in subjects that were not previously considered medical" (Gönç-Şavran, 2010: 38). Therefore, as Bauman (2017: 125) states, situations that were considered normal and satisfactory in the past are now considered alarming and even diseased and are trying to be treated.

Today's relationship between health/disease and society unfortunately reinforces a system that produces both iatrogenesis and diseases or harms caused by the physician, modern medicine or the health system. Therefore, focusing on the therapeutic practices of physicians, who are the main actors of this system, and analyzing these practices is of vital importance in analyzing the phenomenon of iatrogenesis.

Iatrogenism as a Determinant of the Medical Profession

In the Islamic scientific tradition, the concept of "Hikmet", which means "wisdom", defines both philosophy and medicine. Accordingly, the concept of "hakim" refers to both physicians and philosophers (Rahman, 2016: 163). Today, however, the physicians who possess wisdom have been replaced by doctors in their role as "instructors". Although these two concepts are used in the same sense, their etymological meaning is quite different.

A sick individual applies to a health institution to receive health services for treatment. Each health worker with different tasks in health institutions represents a profession with which the patient can potentially communicate. Among these healthcare professionals, physicians are the professional group with whom patients develop the most social relationships (Açıkgöz, 2021: 124-125). Patient-physician relationships constitute one of the problematics of both the sociology of health and the issue of iatrogenesis.

The modern period redefined the profession of medicine as well as the new understanding of medicine. Bryan S. Turner argues that with the process of secularization in Western societies, the social function of religion declined and medicine filled this void. In Christianity, body and soul were not distinguished from each other and illness was tried to be understood within the holism of body and soul. However, in the modern period, rationalization brought with it medicalization and differentiated the functions of clergy and physicians in society (Turner, 2011: 48). Thus, clergymen were replaced by physicians, churches by medical clinics, religious rituals by diet, sports, birth control, anti-smoking, and confession by psychology clinics. In this sense, Freud's development of psychoanalysis succeeded in producing a kind of "clinical theology" (Cirhinlioğlu, 2001: 51-52).

Foucault states that there is a close relationship between power and knowledge and that doctors gradually gained great prestige and influence as knowledge became a system in the late 19th century (Foucault, 2002; Öz, 2016). According to Max Weber, the doctor is a charismatic personality. The fact that the doctor is charismatic undoubtedly gives him prestige. On the basis of this prestige, patients have feelings of love and admiration for the doctor (Türkdoğan, 2006: 106). In our society, the profession of medicine is seen as superior to many other professions, and especially families from middle and lower-income groups want their children to become doctors when they grow up.

According to Ivan Illich, the medical man of our time is equipped not to understand the problems that pain poses to the sufferer, but to reduce these pains to a "list of complaints" by collecting them in a

file. Proud of his knowledge of the mechanics of pain, he avoids the patient's calls for compassion (2017: 107). Undoubtedly, although the statement that all physicians act in this way expresses a generalization, a significant portion of physicians commonly behave in the manner described by Illich. Orhan Türkdoğan, who has made significant contributions to the literature with his studies on the sociology of health in Turkey, makes the following observations about the patient-physician and patient-assistant health personnel in our society (2006: 53-61, 231):

- The doctor, nurse, nurse caregiver or any other health worker should not intend to judge or belittle the patient but rather should make an effort to get to know the patient's cultural environment and social conditions. Because a patient who comes to a clinic or hospital is not only a carrier of a particular disease but also a representative of a form of culture.
- In our society, patient-physician relationships have a formal character, as opposed to a close and intimate relationship. In our society, there is a common perception that the doctor looks down on the patient because of his/her status. People have expectations that the doctor should be more caring, compassionate, and smiling. It is also known that our people show more interest in religious, elderly, and tolerant doctors.
- In our society, most patients show more interest and closeness to doctors who have been raised in their own social environment. This is because the fact that the patient and the doctor come from a similar social environment and the culture in which they grew up is close to each other brings the patient and the doctor closer to each other.
- In fact, the doctor's "friendly" relationship with the patient is often preferred by the patient rather than the doctor's expertise and knowledge. However, the doctor distinguishes himself/herself from the patient because he/she has a different social status.

Today, issues such as the scope of the concept of disease, who is considered a patient, and which practices to apply to patients and individuals at special risk have been accepted as a matter that only doctors know (Illich, 2017: 41). The decisions made by physicians, who are fictionalized as the holy men of modern medicine, are regarded as absolutely unquestionable commands compared to the fatwas of clergymen. For instance, a Muslim's decision to fast during Ramadan is mostly influenced by the jurisprudence of physicians, not clergymen. Illich describes the "unquestionable power" of physicians through modern medicine as follows.

> *In every society, medicine, like law and religion, determines what is normal, appropriate, or desirable. Medicine has the authority to label one person's complaint as a legitimate illness, to declare another as sick even if he or she does not suffer from any ailment, and to refuse public acceptance of another's pain, disability or even death. It is a medicine that stigmatizes some pains as 'purely subjective', some ailments as disease-mongering and some deaths as suicides. The judge determines what is legal and who is guilty. The priest declares what is sacred and who has violated a taboo. The physician decides what is symptomatic and who is sick. He (the physician) is a moral 'entrepreneur'[1] with powers similar to that of an inquisitor[2] to find some wrong to right (Illich, 2017: 41).*

The medicalization of life carried out through physicians and health systems also refers to the social dimension of iatrogenesis (social iatrogenesis). According to Illich (2017: 120), in today's societies, clinical measurements are spread throughout the whole society. Because society has become a clinic and all citizens have become patients whose blood pressure is constantly monitored and adjusted to normal limits. However, healthy people are those who live in healthy homes, follow healthy diets, and live in an environment equally suitable for birth, growth, work, recovery, and death. Moreover, they are empowered by a culture that consciously accepts population limits, aging, irreversibility, and even impending death. Healthy people have little need for marriage, childbirth, humane conditions and bureaucratic intervention in death (Illich, 2017: 199). However, health care has become a standard commodity, a product; all suffering has been "hospitalized" and homes have become unwilling hosts for

[1] The concept of an entrepreneur means "entrepreneur", or "contractor", "entertainment conversation".
[2] The Inquisition is the name given to the church courts that punished people who strayed from Christianity or violated religious principles.

birth, illness and death; the language by which people can understand their own bodies has become a bureaucratic of fan-fon-fan;[3] suffering, mourning and healing outside the role of the patient have been labeled as a kind of perversion, thus activating social iatrogenesis" (Illich, 2017: 38).

Medicalized life is reduced to an interval and a statistical phenomenon that must be institutionally planned and shaped. The life interval comes into existence with the prenatal check-up, where the doctor decides whether or how the fetus will be born and ends with the stop reanimation sign on a patient card (Illich, 2017: 60). The medicalized life between check-up and reanimation is tried to be sustained with medication. According to Applbaum (2014: 101), medicalization, which was not previously considered as a medical condition, but today is the process of including it in the class of disease, dysfunction, or possible dysfunction, also provides the function of "directing individuals to medication". Individuals and health care professionals strategize the use of medication as if it were a "magic formula" for the treatment of the vast majority of even mild ailments.

The problematic nature of patient-physician relations also accelerates today's production of social iatrogenesis. This is because patient-physician relationships are of "vital" importance in the diagnosis and treatment process. In the diagnosis and treatment of the disease, it is essential to establish healthy communication between the patient and the physician and to realize this relationship primarily on the basis of trust (Can, 2019: 35). It is important for the physician to establish a healthy communication with the patient and listen to their complaints in order to make an accurate diagnosis of the disease. In addition, the physician's attention to the patient's privacy, informing the patient about the process of the disease, not showing any signs of verbal violence and mobbing in his/her behavior towards the patient, and treating the patient with sincerity and confidence increase the efficiency of the diagnosis and treatment process. Undoubtedly, these sensitivities are sensitivities that not only physicians but also all healthcare professionals should show to the patient (Can, 2019).

Health institutions, where people apply to receive health services in daily life, are also units where social interactions take place. Especially patient-physician relationships are important practices that people encounter and are affected by in their daily lives. The interaction between the patient and the physician leads the patient to develop positive or negative feelings toward the physician. According to Türkdoğan, patients mostly expect the doctor to establish a relationship with them like a friend. However, the doctor separates himself from his patient due to his social status (2006: 59).[4] According to Elmacı (2013: 39), who holds a similar view, modern medical practitioners sometimes adopt a critical and even contemptuous attitude towards patients. Patients with low socio-economic status are scolded or despised by health personnel when they do not behave in accordance with the expectations of physicians or when they prefer traditional practices. Therefore, in our society, patient-physician relationships are formalized except for closeness and sincerity. Based on this fact, most of the patients show more interest and closeness to doctors from their own social circles, thinking that they will show sincerity and closeness.

Another situation that is ignored in patient-physician relations, and which also prepares the ground for the production of the cultural-symbolic iatrogenesis that Illich categorizes, is the physician's disregard for the patient's health culture with the power he or she has acquired from modern medicine, or his or her belittling of this health culture as primitive. However, according to Cirhinlioğlu, the research of many anthropologists shows that many cultures that Western culture defines as primitive have developed knowledge and value systems that are quite consistent within themselves. Citing anthropologist Byron J. Good's anthropological experiences on health as an example, Cirhinlioğlu mentions Good's suggestion

[3] The characterization fan-fon-fan is a figure of speech used in slang to express unintelligible speech in a foreign language.
[4] In the Islamic medical tradition, medicine and morality are fundamentally informed by the same sources and ideas. The physician has two main moral responsibilities. The first is the patient-physician relationship. The physician is morally responsible to his patients. Therefore, the physician should treat his patients with kindness and patience, show concern and professional trust. The second dimension is the strong belief that without the physician being a good and moral person, the treatment of his/her patients will not yield any results. Moreover, since an immoral physician will not have a good reputation in the eyes of the public, it is unlikely that he will be successful in healing the patient, both physiologically and psychologically (Rahman, 2016: 177-178).

to abandon a philosophy of health that dismisses or ignores the patient's beliefs about their illness and to find a middle ground in this sense. This is because both patients' beliefs and physicians' knowledge should be evaluated in their own social contexts. It should not be overlooked that the approaches of both physicians and patients ultimately aim to treat a specific disease (2001: 50). Moreover, today "the social environment in which both physicians and patients live has become so complex that it has practically lost its meaning to evaluate patients' approaches to their illnesses as irrational and physicians' behaviors as rational" (Cirhinlioğlu, 2001: 50). Day by day, the power of modern medicine in the field of health began to be shaken and the medical methods and techniques that patients resorted to for treatment began to diversify.

The increasing dominance of the private sector in health has also increased the visibility of iatrogenesis. The increasing commercialization of patient-physician relations has transformed health care into a commodity produced under conditions of economic competition. In this relationship, patients are assigned the role of "customer" while physicians are assigned the role of "seller" of commoditized health care (Deppe, 2014: 50). This is because the commercialization dimension of health services regulates patient-physician communication based on a customer-seller relationship. In hospitals owned and managed by the state, patient-physician relations are rather monotonous, formal and hierarchical, and unilateral within the framework of the physician's directives towards the patient, whereas in private hospitals, this relationship is organized based on an ideal two-way communication in which the physician exhibits sincere behavior, listens to the patient and informs him/her about his/her illness, since it is carried out with "commercial" concerns and profit-oriented. Therefore, the relationship of low-income patients with physicians differs from the relationship between high-income patients with physicians in this sense. As Cirhinlioğlu points out, the behavior of patients to apply to a health institution when symptoms of illness appear is closely related to the economic level of the society. Moreover, the motivation of patients to visit health institutions is also related to the structure of these institutions (2001: 52). In other words, a comparison of the patient profiles of public hospitals and private hospitals reveals that while citizens belonging to the lower or middle class generally apply to public hospitals, those with higher socio-economic income levels prefer private hospitals. Undoubtedly, this distinction is not very sharp in Turkey, but it is observed that the general tendency and preferences are in this direction.

Several studies of the health industry can serve as examples of overzealous care, which Kane describes as a form of iatrogenesis. These data are important because they reveal the commercialization of health and the ways in which patients and illnesses are constructed. The first study compares some surgical operations in the United States, Sweden, and Canada. In a comparison of surgical operations in the US and Sweden, which have similar economic and cultural conditions, in 1993, it was found that American physicians performed hysterectomies 2.5 times more than Swedish physicians and resorted to cesarean section twice as much as Swedish physicians. It was also found that American physicians performed coronary bypass surgeries 4.4 times more than Canadian physicians (Deppe, 2014: 46). Although there are groups with similar social variables, the fact that the rates of surgical operations performed in these countries are quite different from each other is undoubtedly thought-provoking about the future of health. Another study consists of questions asked to physicians themselves. In the American Medical Association's intervention study on second-stage prostate enlargement, urologists were asked what kind of treatment they would prefer if they were in the same situation and only 40.5% stated that they would prefer transurethal prostate resection surgery. However, in the general population, this surgery is performed in 80% of patients with second-stage prostate enlargement (Deppe, 2014: 47). The result of the research reveals that physicians are not willing to have the same surgical operation performed on them as they perform on their patients. Another research is related to the use of medical devices. According to Deppe (2014), in Germany, internists who own their own X-ray equipment take on average 4 times more X-rays than physicians who do not, while the German Association of Radiologists states that more than one-third of the X-rays taken in the country are unnecessary. An analysis of arthroscopies of the knee joint in the Netherlands shows that 78% of interventions are unnecessary, with similar findings for microinvasive interventions in the abdominal and pelvic cavities. According to Deppe (2014), the data collected from these countries reveal the following facts about health services: A Health services are interdependent, full of uncertainties, fragile, and complex. It is

also highly vulnerable to external influences. Money, competition, lack of legal security and career ambition, or fear of losing one's job can easily influence conscious or unconscious medical decisions. The studies exemplified here, which focus on physicians, undoubtedly do not cover all physicians. It is certainly not rational to generalize that all physicians see their patients as "customers". For physicians, especially in countries with rich cultural capital like Turkey, human health is not so insignificant that it can be sacrificed to trade. Because, although there are still some problems in patient-physician relations, a significant number of our physicians, who mostly come from middle and lower class families in our country, fulfill their humanitarian responsibilities for their patients, most of whom come from lower and middle class backgrounds like themselves, and treat them according to their conscience.

The conscious risk factor, which is another type of iatrogenism within Kane's classification, clearly manifests itself in medical research. Frauds in scientific studies, especially those conducted under the guidance of the pharmaceutical industry, deliberately put the lives of uninformed patients at risk. Deppe (2014) cites the South Korean stem cell researcher Woo Suk Hwang as a recent case study. This is because Hwang falsified his publications on the possibilities of cloning stem cells. In addition, the following information from the German Medical Association's publication reveals a very grave situation in this regard: "Research fraud: One out of every three researchers is fraudulent. A US study has revealed for the first time figures on falsified data and improper scientific conduct. According to the researchers' own personal accounts, one in three researchers have committed at least one criminal offense in their work in the past three years. The majority of frauds are falsifications of the design, methodology, or results of experimental studies as a result of pressure from financial sponsors (Deppe, 2014: 51). In other words, pharmaceutical companies that sponsor research interfere with the results of research and publicize falsified data to create a favorable environment for the sale of their own drugs.

Another issue related to the pharmaceutical industry is the publication of the results of studies authored by the pharmaceutical industry itself in "guided symposia" organized with the support of medical faculties or professional conferences and financed by pharmaceutical companies. The money spent on prominent academics to publish these research reports constitutes the largest item in the industry's marketing expenses with a share of 20 percent. Even advertising expenditures lag behind by 14 percent (Applbaum, 2014: 102). The pharmaceutical industry is also making efforts to lower the age of drug use in order to reach a wider target group. For example, the health news in the New York Times of July 7, 2008, included the following statements: "Pediatricians in the country recommend expanding cholesterol screening in children and lowering the age of starting cholesterol-lowering drugs to 8 to prevent heart problems in adults." (Applbaum, 2014: 113). However, without raising awareness among parents about how to feed their children, without providing schools with the necessary resources and adequate equipment to improve physical education programs, and especially without understanding the long-term effects of lipid-lowering drugs on children, allowing children to be exposed to such a chemical (Applbaum, 2014: 113) will cause children to be exposed to many diseases in their later years. According to Applbaum (2014), the pharmaceutical industry aims to produce so-called "nichebusters" and "personalized" drugs in order to expand its marketing network, and maximize its profit rate. With sectoral conferences, symposiums and publications claiming to be scientific, nichebuster drugs are entering the literature as the next-generation drugs whose marketing strategy has already begun to be determined. On the other hand, the use of medicines has become so commonplace today that they can be consumed without the need for a prescription from a physician.

In response to the iatrogenesis identity of modern medicine, Illich (2017: 120-121) argues that modern medicine faces two sharply opposing paths: The first, which would also mean the continuation of this process, is for the medical profession to further expand its clinical control over people outside the hospital, increasing sickening health care. The second is the radical critical and scientific de-medicalization of the concept of illness as a real challenge. Today, modern medicine, with its gigantic hospitals, the consolidated power of physicians, the presence of a multi-billion dollar pharmaceutical industry, the medicalization of every period of our lives, the new diseases gifted to humanity by distorted urbanization and capitalist industrialization, is rapidly moving along the first of the solutions proposed

by Illich. The second solution will remain there until the time when the value of the social theories that argue that health and illness should be de-medicalized and redefined will be recognized.

Conclusion And Suggestions

Today's societies are experiencing a crisis of confidence in modern medicine. In order to overcome this crisis of trust, a philosophy of medicine in general and a medical epistemology in particular are needed. Illich argues that even before medical biology or medical technology, "medical epistemology" must be put in place to resolve the crisis of modern medicine. Medical epistemology must begin by explaining the scientific status and social structure of diagnosis and treatment of physical diseases. Because every disease is a reality produced by society. Moreover, it has a meaning and the reflex it evokes has a history. Examining these histories will enable us to understand the extent to which the medical ideology imposed on society holds people captive. Illich claims that the potential perspective and effective intervention that can stop today's physician domination and the crisis of medicine can be realized not by physicians but by non-physicians. These non-physicians are social scientists who reinterpret health and illness according to the social and cultural realities of society, who try to explain illness not only in terms of a single cause but also in terms of multiple factors, and who can redefine the understanding of medicine in its many contexts such as history, culture, beliefs, values, traditions, and habits. Önal, on the other hand, proposes a holistic conception of medical philosophy as a solution. According to the holistic perspective, the human being should be considered both as an individual with a natural and social environment; as a superior creature with a world of action, meaning and value that distinguishes it from other creatures, such as culture, religion and morality; and as a creature that thinks, feels and has free will. Therefore, the basic principle of a new philosophy of medicine should be shaped by the understanding of wisdom that includes science and philosophy (Önal, 2007: 152).

In order to achieve the goal of creating a healthy society, it is certainly not enough to utilize only medical knowledge. Social sciences can make significant progress in the field of health when they are included in the process of examination and analysis together with medical knowledge, as in the medical sociology studies conducted in the United States. In other words, the issue of health should be addressed not only as a biological issue but also with a social research motivation that centers on the examination of health conditions (Cirhinlioğlu, 2001). Therefore, as much as medicine is an applied science, it is also a social science when the relationship between health/disease and society is taken into consideration.

Rudolf Virchow, a German physician who lived between 1821-1902, obtained important findings that could lead to a paradigm shift in medicine in his public health research in 1847-1848. Political and economic measures taken in line with these findings led to significant improvements in public health. Virchow's research experience led him to conclude that "medicine is a social science". Virchow's conclusion also significantly influenced the social scientists' view of medicine. Health and illness are not only terms of medicine but also of psychology, sociology, anthropology, and other social sciences, thus necessitating an interdisciplinary approach. In today's hospitals, many physicians encounter patients who are nearing the end of the disease process. Moreover, the disease process begins long before the individual becomes ill and applies to a health institution, but ends in hospitals. Therefore, being healthy or maintaining health can be realized within the knowledge that social sciences will produce in this field in cooperation with medical science (Cirhinlioğlu, 2001). Therefore, as Cirhinlioglu points out, health is too serious a matter to be left only to those with medical knowledge.

In conclusion, another medical profession is certainly possible. Medicine in general, and physicians in particular, need to engage in a kind of self-criticism by considering the issue of iatrogenesis. This self-criticism should start with the epistemology on which modern medicine is based. The medical education curriculum, which is steeped in bio-medical philosophy, will undoubtedly be as inefficient as possible in producing another medical profession. Therefore, medical education that is freed from the identity of iatrogenesis will begin to change the way it views health, disease, the patient, and human beings. From this point of view, the following recommendations of this study may provide a small step towards the construction of "another medical profession":

- Modern medicine should move as far as possible away from the bio-medical approach that sees the body as a machine. This is because the idea that when tissues or organs are damaged, they can only be treated by physical or surgical intervention constantly generates both clinical and social iatrogenesis. Because it is now known that a clichéd treatment method does not evoke the same reaction in every patient.
- Modern medicine should try to understand the basic postulates of bio-socio-cultural approaches and even modern medicine should be reconstructed on the basis of psycho-social and cultural approaches. Of course, this study does not suggest that modern medicine should be completely replaced by traditional methods. In fact, modern medicine, with its many innovative techniques, plays a major role in the treatment of many people today. The point to be emphasized here is that today's medicine, with all its tools and devices, needs to realize a major paradigm shift. The restructuring of modern medicine requires the filtering of medicine from bio-medical residues and the construction of this new paradigm on a new epistemology of medicine centered on the human being.
- Medicine is also a social science. The nature of current medical education ignores the social dimensions of health and illness. However, the sustainability of health and the causes of the disease requires a more comprehensive explanation than just structural damage to tissues and organs. In addition, when medical education curricula are examined, it is seen that an understanding of education organized as much as possible on the bio-medical axis is dominant. However, educational philosophies that do not take into account the psychology of the patient and the sociological and anthropological dimensions of the disease construct the human being or the patient as an object rather than a subject. This is because the patient who comes to be examined or is undergoing treatment is also a representative of a culture, a carrier of beliefs, values, thoughts, or philosophies. In the words of Canadian physician William Osler, "A good physician deals with the disease, a master physician deals with the patient." In other words, medicine or the medical profession, which has an iatrogenesis identity, considers taking care of the disease as an achievement and misses the patient, the human being.
- The vision of "another medical profession" should bring new principles to patient-physician relations. A physician who can provide healthy communication with his/her patient based on trust instead of unethical habits that look down on the patient, belittle the culture the patient comes from, do not provide adequate information about the process of the disease, does not pay attention to patient privacy, apply verbal violence to the patient and see the patient as a customer, A medical profession that pays attention to the patient's privacy, adequately informs the patient about the process of the disease, sees the patient not as an object of commerce but as a subject to be healed, in short, a medical profession that can be abstracted from all the morbidities of social and cultural-symbolic iatrogenesis, can produce another and new medical profession.
- The life we live is a medicalized life. People are now born in hospitals and die in hospitals. Because life begins and ends in the hospital (Tekin, 2016). Today, most of our life between this beginning and end is made up of hospital visits. Interestingly, as the number of hospitals increases, the number of patients in society also increases in masses. In other words, health today is confined to hospitals. Being healthy becomes a reality with the tests or reports you receive from a hospital or a physician. However, health is a comprehensive social institution that cannot be explained only in hospitals. In addition, health is embedded in all the practices of the individual in his/her social life. Preventive medicine, or "sanitation" in its traditional usage, is essentially the health practices that take place in the flow of life such as eating and drinking, working, sleeping, cleaning, sports, resting, sexual intercourse, and living spaces. Medicalization is therefore the "heart" of all forms of iatrogenesis. Another profession of medicine should have a mission that does not let the individual fall into the spiral or vortex of medicalization, that does not allow the patient to enter the tunnel of fear by depicting the worst case scenario, that does not disconnect the patient from the flow of daily life by assigning new tasks and roles to the patient and thus eliminates your cultural-symbolic iatrogenesis.

- Another conception of medicine should not view health and illness as an instrument of the health industry. The forms of iatrogenesis defined by Kane's concepts of "incompetent care" and "overzealous care" and Illich's clinical, social, and cultural-symbolic concepts are important elements that today's physicians, health policy makers, and health service providers should take into account. Because many "morbid habits" such as over-diagnosis of patients, profit-making strategies of the pharmaceutical industry and physicians aligned with this industry, unnecessary use of medical devices and surgical operations, guided symposiums that serve the goals of the health industry should be practices that no other medical profession or "new ideal type of physician" would engage in. Therefore, physicians should be aware of "self-inflicted damages" and avoid behaviors that may put the patient's health at risk during the treatment process. This principle also constitutes the basic character of medical ethics.

Undoubtedly, many more suggestions can be added for a "new ideal physician type" free from iatrogenesis. In fact, with new studies to be conducted in the field of sociology of health, the investigation of modern medicine, the profession of medicine, in short, all the apparatuses of the health institution, will open the door to the strengthening of a new "human" centered medical philosophy. Undoubtedly, as the different dimensions of health and illness are discussed, the "construction of another medical profession" will be realized in a powerful way.

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