

Whatever Happened To Medical Politics?

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ABSTRACT:

In this paper I argue the case for coming to see ‘medical politics’ as a topic or subject within medical education. First I note its absence from the wide array of paramedical subjects (medical ethics, history of medicine, the medical humanities etc.) currently given attention in both the medical education literature and in specific curricula. I suggest that ‘the political’ is implicitly recognisable in the historical roots of medical ethics education, specifically in certain of the London Medical Group’s (LMG’s) activities. I also suggest that the medical profession, or indeed any profession, cannot be understood as an apolitical form of social organisation either in its institutional or scientific (epistemic) forms. I then discuss some brief suggestions for introductory and advanced topics in medical politics and consider the degree to which medical politics ought to be taken seriously and delivered as part of medical education. Ultimately I conclude that medical politics might be considered a useful subject within medical education but is perhaps best understood as a perspective or approach which can contribute to the development of a more expansive perspective within the extant paramedical subjects.

Keywords: Medical Politics, Paramedical subjects, Education, London Medical Group.

INTRODUCTION:

Both prior to, and as a result of, 1993’s Tomorrow’s Doctors [1] many non-biomedical science courses, ranging across such diverse disciplines as sociology, anthropology, history, literature, the humanities, law and perhaps most notably ethics, were to a varying degree incorporated into the undergraduate medical curriculum in the UK. This continued a traditional tendency of medicine towards incorporating, utilising or co-opting ‘external’ perspectives on itself for its own (pedagogic) purposes. This is most remarkable in the case of the history of medicine which, historically, was used as both a topic to illuminate medicine

and as an approach to the teaching of medicine.[2] In the case of more recent developments the aim has broadly been to develop and expand the perspective of medical students and medical practice; to humanise medical education. As with Tomorrow’s Doctors itself, the incorporation of these ‘paramedical’ subjects into the curriculum has been part of the drive to modernise medicine and medical education. This paper briefly considers some of these paramedical subjects and notes the absence of anything explicitly identified or identifiable as ‘medical politics’.[3]

Before considering what a subject entitled ‘medical politics’ might consist of it is useful to consider what we might mean by politics or ‘the political’. Such a definition is elusive, possibly due to the political implication of any such definition, Heywood [4] however offers four notions that can form a useful basis for discussion. First, and most obviously, there is the government or the state and so the relationship of the medical profession with the government is a topic central to medical politics. Second Heywood suggests that politics is linked to public life or the management of a community’s affairs. If we consider medicine and the medical profession as a self governing community engaged in public service we can see that medicine is unavoidable political in this sense. Third Heywood identifies ‘conflict resolution’ or ‘compromise, conciliation and negotiation’ as being political. Here we can see a wider conception of politics is being drawn. Most, if not all, areas of human life have the potential to involve a degree conflict and resolution; in this the various arenas of medicine, from the activities of Royal Colleges to the individual Doctor-Patient relationships, are no different. This wider drawing of ‘the political’ can lead to a more theoretical understanding of politics as involving social relations of power, a perspective which gives credence to Aristotle’s suggestion that man is by nature a political animal.[5] Heywood final notion of politics appeals to a more Marxist perspective seeing it linked with the ‘production, distribution and use of resources’ something we consider of central importance when discussing the various merits of healthcare organisation and delivery. Again this draws on social relationships and power in defining the political.

In this paper I try to draw out some of the ways in which various conceptions of the political could be usefully applied to medicine with a particular focus on doing so for the purposes of educating medical students about the medical profession as well as informing their medical

ethics education. First I consider if we have ‘lost’ the more obviously political aspects of early medical ethics education in the UK before turning to a discussion of the institutions of the UK medical profession as political entities in both their external, internal and ethical dimensions. I discuss what topics might fruitfully be taught under the banner of ‘medical politics’ considering both introductory and advanced levels before concluding with a discussion of the limits and value of engaging in such education. I surmise that it is perhaps advisable to understand my suggestion for a medical politics more as an approach which might refresh the views of medical educators with regard to various paramedical subjects but particularly medical ethics.

THE PARAMEDICAL SUBJECTS:

Medical students take courses in medical ethics, medical law, the history of medicine, medical sociology and in the medical humanities, a growing area of medical pedagogy. Each of these topics appears, to a greater or lesser degree, in the specific curricula of the UK medical schools. With regards to sociology, or perhaps the social sciences more generally, both the sociology *of* medicine and sociology *in* medicine (epidemiology, community or public health) is taught. Others, anthropology for example, might appear only minimally, perhaps during lessons on cultural competency, as small Student Selected Component’s (SSCs) or as an aspect of a sociology course.[6] Still others such as, medical ethics, receive a mandate from the General Medical Council (GMC) and are a formal requirement aspect of the undergraduate medical curriculum in the UK. It appears prominently across both the core curriculum and student selected components of UK undergraduate medical degrees. However whilst this diverse range of disciplinary perspectives in and on medicine and medical practice appears to include nearly all the subjects found in the arts, humanities and social sciences it does not appear to include politics.

The absence of anything we can directly consider ‘medical politics’ in this paramedical line-up might be the result of the absence of any such sub-discipline from politics itself. This is clearly not the case with history (history of medicine) and sociology (sociology in/ of medicine) and so forth. Both of these disciplines, sociology and history, have explicitly political dimensions and it might well be the dominant influence of these particular sub-disciplines that has perhaps rendered ‘medical politics’ as an arena for research somewhat

redundant. For example consider the sociology of the professions. This is a major topic of study independent of medical sociology which we might say examines George Bernard Shaw’s adage that “all professions are a conspiracy against the laity.”[7] Social history of medicine has gone beyond merely considering this ‘conspiracy’ and articulated the ‘view from below.’ Indeed social studies in the history of medicine have played a central role in articulating the ‘history from below’ paradigm which is now widespread in the parent discipline.[8] My argument is not so much that the discipline of politics should develop a specific concern with and for medicine, the relevant facets of the subject are adequately covered elsewhere. Rather my argument is that in the context of medical education a focus on various political dimensions of medicine can add something to the curricula that we might think both missing and important.

A ‘LOST’ POLITICAL DIMENSIONS OF MEDICAL ETHICS?

We might think that as well as being a paramedical success story medical ethics is fundamentally related in a number of ways to the idea of medical politics. Issues such as the allocation of resources, which range from new medical technologies such as renal dialysis,[9] expensive pharmaceutical drugs or organs for transplantation, have an obvious political as well as ethical dimension. They are ‘conflicts’ which represent social arrangements and power relations and demand some sort of public and publically acceptable resolution. In the UK the teaching of medical ethics can be traced to the activities of the LMG[10] whose 1981-82 lecture program certainly evinces a political dimension (see Table 1). Many of the topics discussed of course continue to be addressed by medical ethics and medical ethics education yet the specific titles exhibit a certain political dimension that is for the most part absent from current bio- and medical ethical debate. This may or may not be a bad thing. For example the ‘letting die’ of severely ill neonates is clearly a topic which continues to ethically concern the healthcare professions and professionals involved in neonatal paediatrics as well as medical ethical commentators. Yet the ‘Survival of the Weakest’ title given to the 1981/82 LMG lecture references evolutionary theory and eugenics both well worn devices of political rhetoric which cannot now be perceived without a certain ambivalence. One presumes that the title was intended as a provocation which would not now be acceptable.

Other topics demonstrate a generalised concern for wider social changes and their implications for medicine. One assumes the lectures on the ageing population must have partially been focussed on how medical expertise and institutions could respond to the needs of individuals and the state in managing the healthcare demands of an older population whilst those on marijuana on medical science's role in advising the government and public on recreational drug (ab)use. This is of course an issue which has recently concerned the UK in the form of Professor David Nutt and the Advisory Council on the Misuse of Drugs (ACMD) when he compared the risks of recreational ecstasy use to those associated with horse riding.[11] The resulting furore and debate certainly was not for the most part presented or considered in medical ethical terms. Nuclear war was a particularly troubling political issue of the late 70's and early 80's and it is difficult to imagine that the discussion was solely focussed on the obligations of doctors in the event of a nuclear holocaust; we might expect the issue of disarmament to have been discussed. The topic regarding mothers and birth cannot now be considered without a feminism frame, although perhaps Savulescu would argue otherwise.[12]

Table 1: *Selected Lecture Titles from the 1981-82 Session of the LMG.*[13]

Survival of the Weakest: The morality of inaction in the care of the malformed infant.
Life at all Costs: Transplants and Scarce Resources.
Marijuana: its medical effects and social implications.
Kill or Cure: The role of the doctor in nuclear war.
Is Birth too Important to be Left to Mothers?
Behaviour Modification: Brain Washing or Psychiatry?
Diagnostician, Practitioner and Therapist: Is the new nurse a threat to the medical profession?
The rise of Gerontocracy: The impact of pensioner power on society.

As represented by the LMG topic regarding the 'new nurse', conflicts for the control of particular domains and aspects of healthcare and medical work are of course political and have been a feature of modern medicine since its inception. Consider the dispute between medicine and midwifery for control of birth, for example. Indeed if we consider that the

institutions of the modern medical profession are founded on a system of Guilds we can see that the assertion of economic control over medical work is foundational to the inauguration of medicine in its modern institutionalised form. As Hamilton puts it: "Like the guilds and trading companies, the eighteenth century [medical] professional organizations fought to maintain or enlarge their monopolies, to secure legal definitions of their rights and privileges, and to prevent too many members rising from the 'journeyman' class." [14] Interprofessional struggle has a long lineage in the history of medicine and the professions more generally. This lineage continues to shape the forms of medical practices today and its fundamentally political nature should not be ignored.

Finally whilst the ethical dimensions of psychiatric practice are of fundamental importance the speciality cannot be disentangled from its social, cultural and political dimensions. Psychiatry can certainly be seen as a political tool as, infamously, it has been used as such a tool by various regimes across the world. However the categories it produces and propagates can also be understood as 'political' out with more blatant misuse and abuse. Think, for example, of the changing attitude of psychiatry and medicine towards alcoholism and homosexuality for example.[15] Particularly in the area of mental health, but also in medical practice more generally, it is often difficult to separate medicine from morality, in its broadest sense, from the cultural and political norms of professions and/ or society.[16]

MEDICAL INSTITUTIONS AS POLITICAL INSTITUTIONS:

In British political life medicine and healthcare or, more specifically, the NHS is perhaps the single biggest issue. It is difficult to think of another major area in British politics which is of greater concern to the electorate than health and the NHS; no UK party could be elected to power without an acceptable position in regards the NHS.[17] This affords the various institutions of British healthcare a central role in public life. Whilst the GMC might be free from direct 'day-to-day' political interference as it reports to the Privy Council, rather than the Government of the day, it remains a fundamentally political, and politicised, organisation. In addition the various Royal Societies and the Nursing and Midwifery Council all act in a political manner and are involved in political debates. All of these bodies attempt to retain a sense of political independence, particularly party-political neutrality, in order that they might be seen as objective in articulating political positions in regards their professional interests,

practice and knowledge. Yet political independence does not equal apolitical status. One might also think similarly for the BMA which is in fact a trade union and so more obviously a political entity.

The way in which the ethical issues of modern medicine are addressed at a political level is often through the creation of politically independent or arms-length bodies, the HFEA and NICE being two such examples. Of course medicine and the other healthcare professions directly contribute to these debates through a variety of channels. Where such debates become more contentious, or, perhaps, where these debates are awaiting political resolution, the formal institutions of medicine might take a more reticent and conservative line but this does not prevent independent organisations comprised of medical professionals engaging in more direct political discussion and lobbying. The recently formed Healthcare Professionals for Change being a current example of this in regards the euthanasia debate.[18] A deeper appreciation of the involvement of the institutions of medicine, individual medical practitioners and autonomous interest groups comprised of medical professionals and/ or others can be gained through considering the history of the 1967 Abortion Act. The Act was produced through a complex political interplay between medicine, previous attempts at reforms (including the presentation of Acts to Parliament), the Abortion Law Reform Association (ALRA), members of the Church of England, and Member's of Parliament, particularly David Steel who brought the Private members Bill.[19] If one considers that a central concern was for backstreet abortions, which were perceived as the inevitable result of criminalisation the Act can be seen as a negotiated political compromise This political and pragmatic compromise extended to the recognition of medical and other healthcare professional's right to conscientious objection.[20]

We can see that medical professionals and their institutions[21] are engaged in the political life of the UK and can wield a good deal of influence. This is, of course, as it should be. The political debate in regards these issues would be severely impoverished were the healthcare professions to eschew such engagement. However there is another way in which medical institutions can be seen as political: just like any other large institution there is necessarily a degree of 'internal politics'. In some cases the medical profession can simply reproduce the prejudices and politics of wider society. An historical and extreme example can be found in

Pappworth being denied a consultant's position on the basis that he was a Jew and "no Jew could ever be a gentleman." [22] Similarly the gender politics of our society also exist within the medical and healthcare professions. A recent autobiographical medical memoir, *Direct Red*, discussed such issues.[23] If anything I feel that the wider healthcare professions are to be congratulated on their recent engagement with the issue of gender, although this is not to suggest that there is no longer an issue. I have little doubt that this is in no small part down to what has been called the 'feminisation of medicine'. [24] The contours of the debates regarding gender within the healthcare professions are certainly an example of internal politics.

However internal politics can also be more minute and focussed. Whilst a system of patronage, with all that implies, used to characterise medical education and guard the career ladders of many medical specialities it has been effectively challenged. Perhaps unavoidably there remains a small 'p' political dimension to medicine but it would be incorrect to single out medicine for particular criticism on this count; wherever there are people and organisations we might expect there to be politics with a small 'p'. We must acknowledge that if small p politics is an aspect of any institutionalised human organisation then it is a part of medicine. Admitting this is a step in the direction of facing any overly negative consequences of this part of our social nature. Having done so the scope of medical ethics could be considerably expanded through explicitly addressing the troubling aspects of 'power' at micro, meso and macro levels.

WHAT COULD WE TEACH IF WE TAUGHT MEDICAL POLITICS?

The preceding section briefly demonstrated that, particularly in its relationship with wider society and culture, there are inescapable political aspects to medicine as a science, as both a profession and as a practice. In this section I wish to suggest some topics that might be covered under the heading 'medical politics' in the course of undergraduate medical education. I have divided these into introductory and advanced level topics which one might suppose could map onto undergraduate and postgraduate medical education. However it might be better to think of these as potential topics for discussion at the undergraduate level or as part of an intercalation degree in either interdisciplinary ethics or the medical humanities, both current growth areas in UK medical education. Of course this would also

indicate that the advanced topics in medical politics could also form part of master level education in these subjects aimed at medical professions, and perhaps also the recent development of such course focussed on ‘Professionalism’.[25] Indeed reflection on the political dimension of professionalism as a concept and movement within medicine (and other professions) might have much to recommend it.

One caveat I wish to specify is that some, although certainly not all, of the topics proposed may already form part of undergraduate medical education, particularly in courses such as ‘The Doctor and Society’ or ‘Medicine in Context’ which can often be found in the first year or two of most UK undergraduate courses. Furthermore it may be that my suggestions for introductory topics in medical politics can and should be accommodated within these courses. However I think that the advanced topics suggested below would benefit from being discussed in a more diverse context. One way to achieve, or at least increase, the possibility of this might be through either taking an interprofessional approach or through teaching medical students alongside those from politics or other arts, humanities and social science courses. Unfortunately the structural realities of universities are likely to militate against achieving this in practice, particularly in the cases where faculty boundaries must be crossed. Nevertheless, with some creative thinking, it may well be possible to produce an innovative course which at least introduces medical students to political aspects of the medical profession.

Introductory Topics in Medical Politics

Some basic introduction into the political arrangements of the UK and elsewhere might be a useful place to start. It cannot be assumed all medical students are aware of the complexities of the medical profession, its organisations and their relationship to and with the government. The issue of private medicine can provide an excellent platform from which to lead into a discussion of a number of political topics including health insurance, the limits of national provision, cosmetic surgery, dual systems and ‘queue jumping’. There is also a number of what we might call ethico-political issues which, perhaps due to the predominant political, rather than ethical, dimensions, can be neglected by medical ethics education aimed at medical students. Finally consideration might be paid to the doctor as an agent of the state; as someone who is asked to certify the health or illness of their patients for an increasing variety

of purposes. Discussion of these issues can be used to raise not only questions of medical ethics but also the wider responsibilities of the profession. For example responsibility to protect patient confidentiality at the level of the individual, i.e. in specific cases, but also to defend it at the political level, i.e. as a conceptual and practical basis of medical practice.

Table 2: *Introductory Topics in Medical Politics.*

The professions as political entities: The GMC; the Royal Colleges (including Nursing, the Midwifery council, and other allied healthcare professions); the BMA; and MDU.
The NHS, the Welfare State, Private Medicine, and other forms of health and social care provision including dual provision.
Ethico-Political Issues facing Medicine and Medical Professionals: Capital Punishment; Involvement in torture; Conscientious Objection (Abortion and War); Professional Guinea Pigs; The internationalisation of Medical Research.
The Doctor as Agent of the State: DVLA; Certifying sickness or disability; (un)Fitness to plead, stand trial and tests of legal responsibility;[26] health check-ups for insurance purposes; Military and Police medics; Gun control; certifying fitness to plead.

Advanced Topics in Medical Politics.

At the advanced level boundaries between medical politics and other paramedical subjects and disciplines become blurred. This is in line with the absence of any substantive sub-discipline located within politics directly concerned with medicine. Consequentially medical politics becomes a particular, but interdisciplinary, perspective which can bring other paramedical subjects into dialogue with one another under a political rubric. An additional dimension is added to the discussion of the topics contained in Table 3 if we adopt an explicitly political perspective. Insights from the sociology of the professions, historical perspectives on the process of professionalization and on medical culture can seem somewhat abstruse to practically minded medical students and professionals. Thus a focus on the more practically orientated political dimension could contribute to rendering these topics more relevant. Through highlighting the political aspect of the more structurally normative issues in regards medical practice and organisation, which perhaps remains implicit in the analysis offered by some paramedical subjects, can be placed at the forefront of discussion.

Table 3: *Advanced Topics in Medical Politics.*

The History of the NHS and the Welfare State.
The Process of Professionalization: Historical Fact or Ongoing Reality?
Psychiatry as a political tool: USSR; forensic and anti-psychiatry; Community Treatment Orders.
The Normal and the Pathological: The Politics of Medical Science. Disability studies. Anti-Psychiatry. Patients as Men, Women & Children. Issues in Race and Culture.
Medicine and Ideal Bodies: Health or Beauty? Cosmetic Surgery; Liposuction; natural variation of bodies; Obesity and Social Stigma;
Issues of Responsibility, Remuneration, Status and Respect: Doctors, Nurses and Social Workers.
The professional is political: The political dimensions of the professions: Gendered professions/ specialities and professionals.

CONCLUSION

My suggestion for a medical politics does not propose a new research discipline nor does it argue in any strong sense that the suggested topics are unjustifiably absent from the medical education. Some are present in medical curricula and whilst others may be absent my proposal is not that they are fundamentally necessary to modern medical education in the way that the subject of medical ethics is necessary. What is innovative in my suggestion for 'medical politics' is its potential for developing different perspectives on existing topics. Thus the idea of medical politics need not necessarily open a new front in the battle for curricula time but might simply provide a new perspective from which medical educators can refresh and re-engage with their subjects and students. I would suggest that this is particularly valuable in regards certain ethical issues, particularly those which cannot have their political dimensions removed; the issue of professional power produced via the historical and sociological process of professionalization for example.

The shift I propose from the ethical to the political is largely perspectival one. This might also benefit UK medical students who may be culturally inclined to a kind of naive

relativism. Such an inclination is certainly comprehensible in the context of modern medical practice which is disposed towards a non-judgemental or non-directive, value free, approach to professional clinical practice. It is also consistent with the wider culture of the UK and there is little reason to assume that medical students differ greatly in this regard from their non-medical peers. To engage with this fully comprehensible reluctance to make normative judgments as individuals, medical students can be encouraged to consider the medicine as a whole; as a professional group and a political entity. The pragmatic necessity to adopt particular positions on specific (ethical) issues can then be highlighted. Thus the focus of classroom debate can be shifted from developing the medical student's own individual ethical position as nascent professionals to the development of medical student's political perspectives on and for the profession they aspire to join. Ethical responsibility is clearly something to be encouraged in individual medical professionals and I do not wish to take away from the attention paid to this in the UK medical curricula. However I would argue that encouraging medical students to comprehend the ethico-political responsibilities of the medical profession and its institutions, which are among the most powerful professional bodies in any society, is also a laudable aim that is currently neglected.

Having argued the case for a medical politics in my closing remarks I should like to directly consider the limits of the proposal. Whilst it seems to me that encouraging medicine and medical professionals to be able to see themselves in a political light, as 'political actors' and entities, encouraging the entire profession of medicine to become more explicitly political would not be an overly good idea. Nevertheless it is the case that the medical profession is not, and cannot be, an apolitical entity and as such it would be valuable to explicitly acknowledge the political dimensions of medicine in the course of undergraduate medical education and to develop this perspective within the profession itself. There might then be value in delivering some education in medical politics to some medical students either as part of the existing curriculum or in specific modules, most likely SSC's or as part of intercalation or masters degrees. Medical students with an interest and propensity to study the subject as an elective should be provided with the opportunity to do so and, through doing so, might be prompted to further pursue this interest in either formal or informal context and/ or in a professional or private capacity. Were we to do so we would promote reflection, on the part of future medical professional, on the role that the profession and its individual members play in political life of a nation state. Considering that the medical careers website run by the NHS

promotes not only medical ethics but also medical politics[27] as potential career paths the teaching of medical politics could offer long term benefits to individual medical students and professionals as well as to the wider profession and polity of the UK.

BIBLIOGRAPHY

[1] Tomorrow's Doctors. 1993. The General Medical Council. London, UK. The discussion conducted in this paper focuses on the UK as that is where my knowledge lies. Readers can no doubt discern the relevance of the argument to other national contexts.

[2] See: Burnham JC. What is Medical History? Great Britain: Polity Press. 2007:2-3. Burnham differentiates between the eras 1700 CE to 1800 CE and then 1800 CE to 1900 CE where the medical profession's conceptualisation of medical history moved from being one of representing the "eternal truths on which the practice and profession of medicine was based" to an "adopting the general idea of progress" commensurate with the development of scientific methods in medical practice and education, the development of which occurred around the same time as this transition.

[3] For reasons of space, and because of the complexity of the debates raised, I am going to ignore the concept of biopolitics which, in any case should be considered sociology rather than politics.

[4] See entry 'Politics' in Heywood, A. Key Concepts in Politics. Hampshire, UK: Palgrave. 2000:33-35.

[5] It appears Aristotle might have considered being by nature political as not something restricted to man and so perhaps akin to social or co-operative. For further discussion see: Mulgan, RG. Aristotle's Doctrine That Man Is a Political Animal. *Hermes* 1974;102:438-445.

[6] Although we might see the influence of medical anthropology in concern for the 'cultural competence' of medical students.

[7] Shaw GB, *The Doctor's Dilemma*. Fairfield, IA: 1st World Library - Literary Society 2004: 44.

[8] Both of which have not only been central to the history of medicine but the development of these perspectives in the history of medicine have been highly influential in the wider discipline of history itself.

[9] The advent and ethical analysis of dialysis was central to the early development of medical ethics in America. Jonsen AR, *The Birth of Bioethics*. New York: OUP 1998:211-217.

[10] Whong-Barr M. Clinical ethics teaching in Britain: a history of the London Medical Group. *New Rev Bioeth* 2003:73-84.

[11] Nutt, DJ. Equasy — An overlooked addiction with implications for the current debate on drug harms. *J Psychopharmacol* 2009;3 -5. The political fallout from this government advisor on drugs consideration of the comparative risks and social impact of horse riding with ecstasy use led to his dismissal from the ACMD revealing the political nature of this supposedly apolitical advisory body.

[12] Savulescu J, Future People, Involuntary Medical Treatment in Pregnancy and the Duty of Easy Rescue. *Utilitas* 2007;1:1-20.

[13] Hamilton B, The medical professions in the eighteenth century. *Econ Hist Rev*. 1951;2:141–169.

[14] The titles come from a reproduction of an LMG pamphlet concerning their activities in 1981/2 academic year which although entitled 'lecture list' gives no small detail regarding the nature of the LMG at that time. See Appendix 3 of: L.A. Reynolds LA & Tansey EM, eds. *Medical Ethics Education in Britain, 1963-1993*. London: Wellcome Trust Centre for the History of Medicine at UCL. 2007:122-126.

[15] The 1981-82 programme of the LMG discussed above includes a symposium entitled 'Beyond the Medicalisation of Homosexuality' *Ibid*:124.

[16] On the relationship between morality and issues we now think of in terms of mental health see: Martin MW, *From Morality to Mental Health: Virtue and Vice in a Therapeutic Culture USA*:OUP 2006; Of course where the cultural and political norms of a profession are brought into consideration is precisely where concepts of biopolitics and knowledge/ power begin to be relevant. See Turner on Foucault: Turner BS, *Medical Power and Social Knowledge* London: Sage 1987:9-17.

[17] It remains to be seen whether the current government's proposals for reforming the NHS and GP consortia are 'acceptable'. What is certain is that there is a great deal of concern for the potential impact of the proposals. Regardless these were not part of the Conservative manifesto prior to the election and there seems little doubt that, were they part of their

election campaign, it would have had a negative impact on the Tory vote.

[18] <http://www.healthcareprofessionalsforchange.org.uk/> [Accessed 1 November 2010].

[19] The socialist-feminist ALRA having been influential in developing the call for reform since its formation in 1936 was alienated from the 1967 Act due to the abandonment of the 'social clause' something required by the institutionalised medical profession. Brooke S. Introductory Paper: Abortion law Reform 1929-68 in Kandiah MD & Staerck G, (Eds) The Abortion Act 1967. London: Institute of Contemporary British History, 2002:16 Available from: http://www.ccbh.ac.uk/witness_abortion_index.php [Accessed 1 November 2010].

[20] Conscientious objection being very definitely an ethico-political principle and not a purely ethical or purely political principle if indeed there are such things. In addition the repeal of the law against suicide and the later legalisation of homosexuality we can also discern Mill's political views, expressed in his famous 'On Liberty', regarding the primacy of individual sovereignty over that of the state. Another ethico-political principle.

[21] And they are very definitely their and not our institutions, a position which has its advantages and disadvantages.

[22] The discrimination against Pappworth predated his famous ethical whistleblowing. However it continued until 1993 when, a year before his death and 57 years after gaining membership, he was appointed a Fellow of the Royal College of Physicians. It is usually that case the members of the RCP are awarded fellowships as a matter of course a small number of years after joining. No doubt the delay was in part due to his whistleblowing, and not continued explicit anti-semitism. Similarly no doubt his whistleblowing was part due to his outsider status, his political position within the field of medicine. Booth C, "Obituary: M H Pappworth," *BMJ* 1994;6968:1577-1578.

[23] Weston G, *Direct Red: A Surgeon's Story*. London: Vintage 2010.

[24] Pringle R. *Sex and Medicine: Gender, Power and Authority in the Medical Profession*. Cambridge University Press, 1998.

[25] Some of my personal scepticism about the concept of 'professionalism' is down to what I perceive as its political dimensions. It can appear to be a restatement and reassertion of professional power and the right of the profession to autonomous control over its own domains, particularly in regards ethics. Perhaps a direct engagement with medical politics in the context of either 'educating for professionalism' or advanced degrees in the subject/

concept might go some way to offsetting these sociological concerns.

[26] The UK Law Commission is currently engaged in a consultation regarding reforming to law on 'Unfitness to Plead' which, it says, should "be informed by modern science, and in particular by modern psychiatric thinking." See:

http://www.lawcom.gov.uk/unfitness_to_plead.htm [Accessed 1st of November 2010].

[27] See:

http://www.medicalcareers.nhs.uk/career_options/alternatives_to_practice/medical_politics_and_ethics.aspx [Accessed 1 November 2010]. The other career alternatives to clinical practice suggested by the same website are: Medical Journalism, the Civil service, Law, medical research, pharmaceutical medicine, medical education and NHS management. Those considering some of these careers might also benefit from my suggestions for a medical politics. http://www.medicalcareers.nhs.uk/career_options/alternatives_to_practice.aspx [Accessed 1 November 2010].