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EXPOSITION

The Managerialist Revolution in Medicine

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Narrative: Medicine has always been hierarchical; but never has it been so conformist, with uncritical, thoughtless physicians marching in lockstep to hit metrics dictated by vested interests that show little concern for sick patients.

Confidence in medicine is falling and I argue that real patients cannot be adequately managed by a diagnostic-based algorithm or treated by an iPad. Medicine is constituted by a particular kind of relationship, a relationship based upon trust between a patient made vulnerable by illness and a doctor who professes to use his knowledge and skills always and only for the purposes of health and healing. No technological advance, no societal development, will ever alter this.

Indexing Terms: Medicine; EBM; managerialism; Technocratic Scientism; Utopian Progressivism; Liberationism.

Introduction

According to Pew research, the number of US adults who place confidence in medical scientists to act in the best interests of the public declined from 40% in 2020 to 29% in 2022.

> *… Healing arises from a relationship based upon trust between a patient made vulnerable by illness and a doctor who professes to use his knowledge and skills always and only for the purposes of health and healing …'*

A 2021 survey by the American Board of Internal Medicine likewise found that one in six people, including physicians, no longer trust doctors, and one in three do not trust the healthcare system. Almost half the population does not trust our public health agencies to act in our interests.

Doctors are leaving the profession in droves, prompting worries of a worsening physician shortage. According to the American Medical Association, one in five doctors plan to leave medicine in the next two years, and one in three plan to reduce their work hours in the next year.

Why is medicine today failing many of its brightest students and pushing large numbers of its best-seasoned practitioners into early retirement? The answer is complex and multifactorial, but a major contributing factor is the managerial revolution in medicine.

Medicine, like many other contemporary institutions since World War II, has succumbed to managerialism, the unfounded belief that everything can and should be deliberately engineered and managed from the top down.

Managerialism is destroying good medicine

Technocratic Scientism

The managerialist ideology consists of several core tenets, according to NS Lyons. The first is *Technocratic Scientism*, or the belief that everything, including society and human nature, can and should be fully understood and controlled through materialist scientific and technical means, and that those with superior scientific and technical knowledge are therefore best placed to govern society. In medicine, this manifests through the metastatic proliferation of top-down 'guidelines', imposed on physicians to dictate the management of various illnesses. These come not just from professional medical societies but also state and federal regulatory authorities and public health agencies.

'*Guidelines*' is in fact a euphemism designed to obscure their actual function: they control physician's behaviour by dictating payments and reimbursement for hitting certain metrics. In 1990, the number of available guidelines was 70; by 2012, there were over 7,500. In this metastatic managerial regime, the physician's clinical discretion goes out the window, sacrificed on the altar of unthinking checklists. As every physician knows from clinical experience, each patient is *sui generis*, unrepeatably unique.

Real patients cannot be adequately managed by a diagnostic-based algorithm or treated by an iPad. Checklists are useful only once the problem has been understood. For the practitioner to be able to make sense of problems in the first place requires intuition and imagination, both attributes in which humans still have the edge over the computer.

Problem-solving in a complex environment involves cognitive processes analogous to creative endeavours, but medical education as currently configured does not cultivate these capacities.

Technocratic Scientism has likewise driven the campaign for so-called '*evidence-based medicine*', the application of rationalised expert knowledge, gleaned typically from controlled clinical trials to individual clinical cases. At first glance, evidence-based medicine seems hard to argue with, after all, shouldn't medical interventions be based on the best available evidence?

But there are serious flaws with this model, which have been exploited by Big Pharma. Studies yield statistical averages, which apply to populations but say nothing about individuals. No two human bodies are exactly alike, but Technocratic Scientism treats bodies as fungible and interchangeable. As my colleague Yale epidemiologist Harvey Risch has argued, '*evidence-based medicine*' (EBM), a term coined by Gordon Guyatt in 1990, sounds plausible but is really a sham.

Of course, physicians have been reasoning from empirical evidence since ancient times; to suggest otherwise only betrays ignorance of the history of medicine. EBM proponents claim we should only use the '*best available evidence*' to make clinical judgments. But this sleight-of-hand is deceptive and wrong: we should use all available evidence, not just that deemed 'best' by self-appointed 'experts'. The term '*evidence-based*' functions to smuggle in the claim that double-blinded, randomised, placebo-controlled trials (RCTs) are the best form of evidence and therefore the gold standard for medical knowledge.

But as Risch explains, '*Judgments about what constitutes "best" evidence are highly subjective and do not necessarily yield overall results that are quantitatively the most accurate and precise*'. Every study design has its own strengths and weaknesses, including RCTs. Randomisation is only one among many methods in research study design for controlling potential confounding factors, and it only works if you end up with large numbers of subjects in the outcome arm.

The EBM model favours randomised controlled trials that only large pharmaceutical companies can afford to conduct to license their products. This results in, among other things, the scrapping of the entire discipline of epidemiology.

EBM's criteria constitute Big Pharma propaganda masquerading as the 'best' expert scientific and technical knowledge. In Risch's words '*Representing that only highly unaffordable RCT*

evidence is appropriate for regulatory approvals provides a tool for pharma companies to protect their expensive, highly profitable patent products against competition by effective and inexpensive off-label approved generic medications whose manufacturers would not be able to afford large-scale RCTs'. Moneyed interests drive so-called evidence-based medicine.

Utopian Progressivism

The second tenet of our managerial ideology is *Utopian Progressivism*, or the belief that a perfect society is possible through perfect application of scientific and technical knowledge and that the Arc of History bends towards utopia as more expert knowledge is acquired. I recall a conversation a few years ago with a nurse ethicist from *Johns Hopkins* who was giving a guest lecture at the medical school where I taught. She remarked that *Johns Hopkins Hospital* used the marketing tagline '*The Place Where Miracles Happen*'. Medicine is clearly not immune from Utopian Progressivism, even if it's only cynically tapping into this ideology for public relations purposes.

Naturally, promising to deliver miracles only sets up physicians for failure and patients for disappointment. When those promised miracles fail to materialise, an incurable cancer is every bit as incurable at Hopkins as it was at your local community hospital, patients feel betrayed and doctors bereft. A humble and realistic acknowledgment of the permanent limits of medicine is a necessary starting point for any sane and sustainable healthcare system.

> Doctors are not miracle workers, much less gods. Science cannot save us

Liberationism

The third feature of the managerialist ideology is *Liberationism*, the belief that individuals and societies are held back from progress by the rules, restraints, relationships, historical institutions, communities, and traditions of the past, all of which are necessarily inferior to the new, and which we must therefore be liberated from in order to move forward.

Contrary to this ideology, there are some things in medicine that will never change. At its foundation, medicine is constituted by a particular kind of relationship, a relationship based upon trust between a patient made vulnerable by illness and a doctor who professes to use his knowledge and skills always and only for the purposes of health and healing. No technological advance, no societal development, will ever alter this. The ends, or purposes, of medicine are baked into the kind of profession that it is, grounded in the realities of health, illness, and the human body.

But today, the ideology of Liberationism seeks to 'free' medicine from these constraints. Why should physicians only pursue health and healing as their goals? After all, biomedical technology can be used for all kinds of other pursuits. In addition to making the sick well, we can make the healthy '*better than well*': through hormones, gene editing, or psychopharmacology, we can make short people tall, weak people strong, and average people more intelligent. These projects of '*human enhancement*' will explode the boundaries of medicine and liberate man from the constraints of human nature. Why limit ourselves to healing when we can turn men into women, women into men, and humans into bigger, faster, stronger, smarter post-humans or super-

humans? Liberationist projects will free man not just from the ravages of illness, but from the constraints of human nature itself.

A thorough critique of projects of so-called enhancement goes beyond the scope of this article. Suffice it to say that our early forays into these domains have proven to be not liberating but dehumanising. To take just one contemporary example, what proponents call '*gender affirmative care*' is quickly crumbling under the weight of evidence showing that puberty-blocking hormones, cross-sex hormones, and surgeries that destroy healthy reproductive organs have not improved the mental health outcomes of gender dysphoric youth.

The United Kingdom and various Scandinavian countries, which have commissioned reports to carefully examine the scientific evidence for these interventions, are quickly shuttering their paediatric gender clinics before additional harm is inflicted on vulnerable young people struggling with body image and identity issues.

However, we did not need this scientific evidence, helpful as it is to make the case, to understand that destroying the function of health organs is not a good idea. How could this entire enterprise possibly be compatible with good medicine, with the goals of health and human flourishing internal to the practice of medicine?

What has unfolded in the last several years with the explosion of gender affirmative care was largely driven not just by the Liberationist ideology, but also by financial considerations and the desire to create a cohort of lifelong patients, entirely dependent on the healthcare system, who otherwise were physically healthy. The result has been a form of institutionalised and medicalised child abuse fuelled by social contagion and sustained by the slandering and silencing of critics. Gender medicine will go down as one of the greatest scandals and follies of medical history, and is poised to soon globally collapse under the weight of its own contradictions.

The fourth feature of the managerial revolution is *Homogenizing Universalism*, or the belief that all human beings are fundamentally interchangeable units of a single universal group and that the systemic '*best practices*' discovered by scientific management are universally applicable in all places and for all peoples. Therefore, any non-superficial particularity or diversity of place, culture, custom, nation, or government structure anywhere is evidence of an inefficient failure to converge successfully on the ideal system; progress always naturally entails centralisation and homogenisation.

As with the so-called '*clinical guidelines*' discussed above, medicine has also seen the recent explosion of so-called quality metrics for medical providers and organisations. These measures, also numbering in the thousands, cost each physician at least $40,000 annually to manage, costs that get passed on to patients.

None of this improves medical outcomes. In fact, they often worsen medical outcomes by mandating a one-size-fits-all approach to clinical care. This compromises physicians' appropriate clinical judgment and discretionary latitude. Doctors are pushed to hit metrics on measurements like blood pressure even if this does not actually improve meaningful outcomes like heart attacks or strokes.

These guidelines are often pushed by industry groups who have a vested interest in expanding disease categories or widening disease definitions. '*Let's lower the threshold for what counts as hypertension or high cholesterol, so more patients get on antihypertensives and statins*', for example. If doctors don't comply, we don't get paid. It does not matter whether more patients on statins fail to save lives. This leads, among other issues, to preventative overprescribing. In the US, 25% of people in their 60s are on five or more long-term medications, rising to 46% of people in their 70s and 91% of nursing home residents. The evidence supporting the use of these drugs is based on younger, healthier people. Nursing home residents are generally excluded from clinical trials of

new drugs. And yet the norm for elderly adults is a multi-drug regimen, often for the prevention of outcomes rather than the treatment of disease. Calling this '*evidence-based medicine*' strains credulity. It is *pharma-driven, profit-driven medicine*.

Conclusion

What primarily ails medicine is not just technical problems, or economic challenges, important as these issues are to address. Our deepest problems are philosophical, fuelled by ideologies that distort the nature and purpose of medicine. The iron cage created by this system is difficult for doctors to break free from.

The only solution, I believe, is the development of parallel medical institutions, entirely new models of clinical care and reimbursement, started by physicians who opt out of this perverse system entirely. It will take creative minds to establish such a system, but the demand is present if we can create the supply.

Medicine has always been hierarchical; but never has it been so conformist, with uncritical, thoughtless physicians marching in lockstep to hit metrics dictated by vested interests that show little concern for sick patients. Will we recognise that the managerialist ideology undermines medicine's goals of health, and summon the will necessary to cut through all obstacles and cut away the excrescences that undermine the ability of physicians to heal?

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