'Health for me': a sociocultural analysis of healthism in the middle classes

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What is healthism?

In this paper, we address what many health professionals see as a common, increasingly uncontainable and personally stressful problem: the beliefs, behaviour and expectations of the articulate, health-aware and information-rich middle-classes. We describe some fictitious case scenarios, which reflect real-life problems that we have encountered in clinical situations as a general practitioner (Greenhalgh) and psychiatrist (Wessely). The scenarios were constructed using a technique called 'critical fiction', in which themes from real cases are systematically extracted and fictionalized into new stories[1]. They are deliberately somewhat stereotypical, and we acknowledge that the perceptions and choices of any individual will not be determined solely (or even predominantly) by the various socio-cultural phenomena explored in this chapter. Nevertheless, these cases serve to illustrate our analysis of the origins and nature of the 'health for me' phenomenon.

Healthism is related to, but should not be equated with, consumerism, which is a broader term with a host of different meanings, depending on context (and, arguably, not appropriate to health care at all[2]). Gabriel and Lang discuss the different faces of the consumer—as chooser, as communicator, as explorer, as identity-seeker, as hedonist or artist, as victim, as rebel, as activist and as citizen[3]. They discuss five broad meanings of the term 'consumerism': a vehicle for power and happiness; the ideology of conspicuous consumption; an economic ideology for global development; a political ideology; and a social movementg to protect the rights of consumers. This last meaning comes closest to the positive connotations of consumerism as applied in health care, for example, to patient-centred medicine, shared decision-making and partnerships[2,4,5]. But the more negative notion of 'conspicuous consumption' is probably the meaning that aligns best with healthism as an individual behaviour pattern and a potential public health problem.

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Case 1: the Taylor-Browns' mercury fillings

Fiona and Bruce Taylor-Brown are a childless couple in their mid 30s. Both work full time in the financial sector, and have difficulty attending normal surgery hours. They are not frequent attenders, but when they do come, they always book the last appointment of the evening and usually arrive late, just as the GP is locking up (on one occasion, they drew up as she was getting into her car). The GP usually reopens the surgery rather than confront them about this behaviour.

One Friday evening, Bruce attends complaining of a 2 week history of generalized weakness, light-headedness, and "a burning feeling going around in the blood". He has with him a printout from the Internet, which attributes his symptoms to the presence of mercury in dental amalgam. He also has the business card of a private consultant who will remove his amalgam fillings on referral from his GP. He asks the GP to sign a claim form so that he can reimburse this 'emergency' treatment on his private health insurance.

The GP examines Bruce and finds three old mercury fillings (present since childhood) but no abnormality. She is unhappy about making a referral for what she sees as an unnecessary procedure, especially to a colleague whose credentials are difficult to evaluate from the information provided. She refuses to sign the private insurance form. At this point, the receptionist phones through to announce that Fiona has arrived and is knocking on the surgery window demanding to be let in, even though it is now 40 minutes past the official closing time.

Case 2: River's immunizations

River is a healthy, breast fed 6-week-old baby who was born vaginally at term in a birthing pool. His mother Laura is a psychotherapist and his father Sebastian is a musician; both are vegans with no personal medical history of note. Laura's young cousin had frequent febrile convulsions until the age of 5 and Sebastian's grandmother had Crohn's disease.

At River's 6-week check, the health visitor confirms that he is developing normally and is ahead of some milestones. His parents attribute this to music played to him in the womb, daily massage, and chamomile tea in his soother. The health visitor advises that River should receive the standard programme of immunizations (diphtheria, tetanus, polio, pertussis and haemophilus at 2, 3 and 4 months, and measles, mumps and rubella as a combined vaccine at 13 months).

At this point, Laura becomes tearful and begins to murmur about one-sided paternalistic advice. She brings out a press cutting that exposes GPs' financial motives for promoting 'unsafe' vaccines. She says she feels victimized, disempowered and pressurized, and reminds the health visitor that all

tests have confirmed that River is doing perfectly well without unnatural chemicals going into his body. Sebastian explains that in any case River is ineligible for the vaccines because of his family history of fits and inflammatory bowel disease, and the fact that as a vegan baby he can't have egg. They plan to give him homeopathic medicine to boost his immunity.

Case 3: Madeleine's body aches

Madeleine Smyth is a divorced housewife in her mid 50s. She has a daughter at university and twin 17-year-old boys. She has a past history of several years' benzodiazepine addiction following its prescription for stress when the children were taking prep school exams. She has now managed to get herself off all prescribed medication, though she takes a proprietary multivitamin-mineral supplement and plant phyto-oestrogens as a natural substitute for hormone replacement therapy.

Madeleine avoids doctors as much as possible, and has recently refused referral for investigation of rectal bleeding. She did, however, have a breast augmentation and liposuction procedure about 10 years ago. She is a member of a private gym, where she attends daily pilates classes and uses the sun-bed.

Madeleine attends one day complaining of aching in the neck and shoulders and difficulty sleeping. Physical examination by the GP confirms some tension of the trapezius muscle and mild restriction of the expected range of movement of both shoulder joints. "I knew it", she exclaims. "I've got fibromyalgia from those silicone breast implants". She asks the GP to write a letter confirming the diagnosis so she can approach a legal firm specializing in compensation claims.

Most health professionals would identify the three fictional case studies as characteristic of a particular subculture within modern western society. 'Culture', according to Hall, can be analysed at three levels: what people say they do, what they are actually observed to do, and the underlying (and often unconscious) belief systems that drive their behaviour[6]. The case studies illustrate a number of behavioural characteristics that tend to cluster in a particular stratum of the health-aware middle classes (Table 1).

Writers on healthism in various traditions have addressed the various effects of the healthism phenomenon—such as its potential to distort public health priorities (for example, *via* pressure from single-issue campaigners[8–10]), its potential to increase health anxiety through media hype and risk inflation[11–17], the potentially huge economic implications of escalating demands for tests and referrals[18–20] (notwithstanding the fact that the bulk of healthist consumption probably takes place in the

Table 1 Demographic, attitudinal and behavioural characteristics of healthism

- Typically young or middle-aged, from university educated, information-rich, semi-professional background
- Vocal and articulate (aware of, and keen to exercise, citizen and patients' rights)
- Health-aware and enthusiastic in seeking information about health and illness *via* books, magazines, Internet
- Generally makes positive lifestyle choices, *e.g.* takes regular exercise, diet aligns approximately with official recommendations, tends to avoid alcohol, though a surprising proportion smoke cigarettes
- Consumes food supplements (vitamins, minerals, fish oil, garlic), alternative medicines (*e.g.* homeopathic, naturopathic) and tonics (*e.g.* ginseng), all of which are attributed 'natural' and 'holistic' qualities, and also frequently 'detoxs' by diet, food supplementation or other methods
- Concerned about 'unnatural' substances (chemicals, vaccines, drugs, additives), especially when there is a civil liberties dimension (*e.g.* fluoridation of water, mass vaccination, pollution, GM foods)
- Particular fear of small, unseen, insidious threats capable of penetrating the body's boundaries (what Helman has termed 'germism'[7])—hence fear of BSE, additives, *etc.*
- Associates science/medicine with danger rather than safety—well aware of crises such as MMR, BSE, Bristol and Alder Hay
- Exercises a high degree of consumer choice (hence, seeks multiple opinions), often in the private sector

private sector), and its threat to the morale and well-being of health professionals[21–25] and to clinical and public health research[26,27]. On a more positive note, others have written on the potential for strategically harnessing the energy of health-aware consumers to build positive clinician–patient relationships[25,28,29] and to drive system-wide quality improvement initiatives in health care[29,30].

But despite the wealth of publications on the *impact* of healthism, there is surprisingly little published research available on the *nature* of the socio-cultural phenomena that are being criticized, resented, and sometimes overtly feared by commentators in the medical and sociological literature. As Hall might have put the question, *what is the nature of the belief system that drives the observable behaviours and declared attitudes listed in Table 1*? To some extent, the answer to this question is speculative since the research literature is incomplete and conflicting, but we discuss below some empirical studies that have contributed to our overall understanding of healthism and related phenomena.

The origins of healthism: "you've never had it so good"

Table 2 suggests some key historical and demographic forces that have contributed to healthism. The author to be credited with coining the term 'healthism' was probably the political economist Robert Crawford, whose article 'Healthism and the medicalization of everyday life' was published in 1980[31]. He argued that excessive attention to one's own health

Table 2 Historical and demographic origins of healthism (compiled from various sources[10,20,30–32,34–38])

- Advances in health technologies in the mid to late 20th century, which had dramatically reduced mortality from acute infectious diseases and increased life expectancy

- Ambitious 'mission statements' of health care organizations and professional bodies (*e.g.* WHO Alma Ata Declaration) which conflate health with not just the absence of disease (can be attained and is amenable to medical technology) but with 'total physical, social and psychological well-being' (probably utopian and certainly not obtained from the medical profession)

- (Consequently), improved expectations for longevity and health status

- Declining fertility rates alongside (for some) rising leisure time and disposable income—creating a sub-population with time and money on their hands

- Rise of consumerist movement, linked in the 1960s and 70s to left-wing anti-authoritarianism and civil rights ideologies, and in the 1980s and 90s more to right-wing, free-market ideologies

- General trend in western society towards reflexivity and self-awareness ('the cult of the individual'), leading to expectations of self-fulfilment and heightened consciousness of minor bodily symptoms and deformities

- Widespread commercialization of health, with heavy media interest in health topics—leading to a climate of insecurity and alarm about disease

- Progressive medicalization of all aspects of daily life including food choices, leisure activities, mood changes and coping with life events

was an undesirable but inevitable consequence of the political ideology, dominant in the late 1970s, which couched many health problems in terms of individual acts and omissions (rather than, say, the acts and omissions of politicians and policymakers of the deficiencies of the welfare state). He thus saw healthism as an ideologically insidious force, which, "…*by elevating health to a super value, a metaphor for all that is good in life, [ ] reinforces the privatization of the struggle for generalized well-being*"[31].

Since Crawford's polemical article, the healthism theme has recurred periodically in editorials and opinion pieces, though we found no papers offering a formal definition of the term. One excellent early overview, 'The Paradox of Health', was published in the New England Journal of Medicine in 1988 by Harvard psychiatrist Arthur Barsky (though he did not use the term healthism)[32]. Reviewing a wide body of epidemiological research and psychometric surveys across the USA, he argued that although the collective health of the nation had improved dramatically over the previous 30 years, there was evidence of declining satisfaction with personal health over the same period. Respondents increasingly reported greater numbers of disturbing somatic symptoms, more disability, and more feelings of general illness.

Barsky and others have argued that healthism may be related to the very success of medicine in addressing disease, hence raising expectations for its far less successful attempts to influence subjective health, well being and quality of life. For the first time in history, modern medicine, which may well be "the greatest benefit to mankind", as Roy Porter put it, raises the illusory prospect that people are entitled to a life not just free

of disease, but also free of symptoms, with the social, psychological and physical all in harmony. He argued that health professionals should become more aware of the paradoxical consequences of medical progress (Table 2) so that they do not inadvertently contribute to a rising public dissatisfaction with medicine and medical care.

On a similar theme, Muir Gray has introduced the concept of 'post modern medicine'—a distrust of science, a readiness to resort to litigation, a greater attention to risk and better access to information (of whatever quality)[33]. Whilst we dispute the conflation of these characteristics with postmodernism, we agree that consumer and patient values increasingly replace paternalistic and professional values in contemporary discourse on health and illness.

McMichael and Beaglehole, writing in the *Lancet* in 2000, attributed the healthism trend largely to the impact of economic globalization[34]. On the one hand, the exacerbation of income differentials, fragmentation and weakening of labour markets (due to deregulation of trade and investment), and widespread environmental damage consequent on globalization has perpetuated poverty-related diseases amongst the poor. On the other hand, the expansion of commodity markets and the availability of fast affordable travel and rapid communication technologies have vastly enhanced consumer awareness and expectations for health, body image and lifestyle amongst the rich.

A good example of the impact of such social, political economic and ideological forces on health choices is the rise of silicone breast implantation in the USA in the years before the procedure was banned by the Food and Drug Administration (and in particular, the combined influence of the media and powerful lobbies of implant manufacturers and plastic surgeons)[37]. Other examples include the influence of the pharmaceutical industry in extending the boundaries of diagnostic entities such as social phobia, attention deficit hyperactivity disorder and obsessive-compulsive disorders as part of a conscious campaign to increase consumer awareness and hence expand markets[39].

The epidemiology of healthism: an exclusively middle-class affliction?

The fictional vignettes in this chapter, which are based largely on our own general impressions, present healthism as a middle-class phenomenon. Of course, consumerism in general depends on disposable income, and expensive health and lifestyle interventions remain the privilege of the rich. But whilst the behaviours and attitudes towards health listed in Table 2 are strongly class-related, the same may not be true of the symptom

clusters and disease entities linked to healthism. We should beware that we view our patients' behaviour, and we attempt to research it, through an unconscious conceptual lens that is distorted by our own preconceptions and assumptions. People from different social classes have differential access to health information (and, equally importantly, different levels of functional health literacy—that is, the ability to understand and communicate information about illness and risk). Such distortions can perpetuate the erroneous notion that certain diseases are more common in the typical articulate middle-class patient.

One of us (Wessely) has a long history of engagement with the problems of chronic fatigue and its syndromes. For many years, it was unusual to find a newspaper article that did not use the epithet 'Yuppie flu' to describe the condition. This was understandable—the same articles contained case histories that frequently conformed to the stereotype of the hard driving professional who had succumbed to his or her illness because of 'weakness' of the immune system brought on by long hours, stress, overactive lifestyle and devotion to duty, rendering the sufferer vulnerable to infection. Most media case histories came from the articulate middle classes, and a surprising number from the health or teaching professions.

This finding was based on empirical evidence—study after study had confirmed the over representation of the professional classes and almost complete absence of ethnic minorities in specialist clinics and self help groups concerned with the condition. But these early studies were methodologically weak, being based on deterministic designs that merely confirmed the researchers' preconceptions and categorizations. As Wessely and latterly others began to conduct rigorous epidemiological studies, it became clear that in reality the *symptoms* that made up the chronic fatigue syndrome concept were actually commoner in lower socio-economic classes and ethnic minorities. But these people were less likely to use terms such as chronic fatigue syndrome or myalgic encephalomyelitis to describe their health problems, and less likely to access medical care at all levels[40,41]. A previous generation likewise concluded that middle class parents and parenting was a particular risk factor for childhood autism, based on samples derived from self help and support groups for autistic families, which did indeed have a marked over representation of the professional classes, telling us much about health care behaviour and nothing about autism (whose incidence has no association with social class[42]).

The agent of healthism: the reflexive, rational, actualizing self

The American psychologist Abraham Maslow, drawing on a number of previous writers whose philosophical influences can probably be traced back to Aristotle, developed what he called a 'hierarchy of human needs'

(Fig. 1), the most basic of which are physiological (food, shelter, sunlight, sex—things without which we cannot survive)[43]. Only once this level of needs is satisfied do we consider the next level (safety, security, order and predictability) and only then do we rise to address even higher levels. In order of importance, these are love (relationships and belongingness), esteem (prestige, recognition, attention), and, finally, self-actualization ('becoming everything one is capable of becoming' especially in the intellectual and aesthetic domains: 'beauty in art and nature, symmetry, balance, order and form').

In order to work towards satisfying these various needs, argued Maslow, the human individual has two further needs: freedom of enquiry and expression (the need for social conditions that permit free speech and encourage justice, fairness and honesty), and, the need to know and understand (to gain and to systematize knowledge of the environment, the need for curiosity, learning, philosophizing, experimenting and exploring)[43]. He argued that people have an innate desire to work their way up the needs hierarchy. He also proposed four key components of a theory of motivation: (a) a need is not effective as a motivator until those below it in the hierarchy are more or less satisfied; (b) a satisfied need is not generally a motivator (hence, once we are physiologically satisfied, safe, loved and attended to, these aspects of our lives cease to hold our attention); (c) frustration of whatever need is being sought adversely affects mental health; and (d) the experience of self-actualization stimulates the desire for more. In other words, this final need, the pinnacle of our humanness, cannot ever be said to 'satisfied' in the way that the others can.
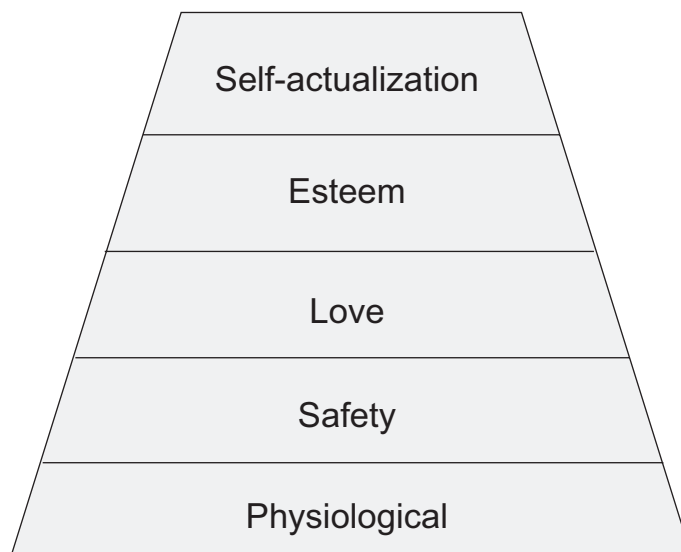

Fig. 1 Maslow's hierarchy of needs.

Whilst Maslow never wrote about healthism, his hierarchical model of need and theory of motivation help to explain many of the behaviours listed in Table 1 and illustrated in the fictional case studies. For example, the model explains why healthism is a particularly middle-class phenomenon; why individuals sometimes pursue the goal of perfect health with such enthusiasm; why the information and explanations provided often fail to satisfy; and why the quest for psychic fulfilment and aesthetic perfection in the body can become self-perpetuating[44].

Australian sociologist Deborah Lupton explored the concept of the self in 60 qualitative interviews with lay people in relation to their encounters with health professionals[45]. Her empirical work was based on a review of the literature on the 'rational, reflexive self' as a product of late modernity: that is, the self who acts in a calculated manner to engage in self-improvement and who is skeptical about expert knowledge. In her fieldwork, she explored the ways in which her participants thought and felt about medicine and doctors. Her findings supported the notion of the rational, purposeful, 'consumerist' self, but she also showed that this somewhat confrontational stance can alternate (and even coexist) with a more traditional 'passive patient' subject position, depending on the context. Lupton concluded that late modernist notions of reflexivity as applied to issues of healthism and consumerism fail to recognize the complexity and changeable nature of the desires, emotions and needs that characterize the patient–doctor relationship. In other words, whilst there is empirical evidence for a healthism construct, it rarely exists in pure form and we should be careful about stereotyping.

Finally, there is the notion of the phenomenological self. The monolithic role of the doctor has been challenged by 'lay experts', whose ability to influence public debate and policy increases as that of the doctor or scientist diminishes—the 'lay expert' may be the survivor of a disaster or the sufferer from a disease[33,46]. We can see how the 'lay expert' has now become a crucial player in many modern health sagas, from the MMR controversy to Gulf War Syndrome—trusted as an individual because their experience is 'authentic', or trusted as a group if allied with a non-governmental organization.

As Marcia Angell memorably described during the conduct of the litigation against Dow Chemical, falsely blamed for the alleged link between silicon breast implants and connective tissue disorders, one witness who had received silicon breast implants successfully refuted a library of epidemiological evidence by simply pointing to her own undoubted rheumatological disorder and proclaiming, "I *am* the evidence"[47]. In this case, the subjective, personal and idiosyncratic (what might be termed phenomenological) evidence was viewed by the jury as more credible than the objective, epidemiological and expert evidence offered by the defence.

Healthism and power

Power has long been a critical theme in sociological writings on health care in general and the clinician–patient relationship in particular. In the early 1950s, sociologist Talcot Parsons painted a distinctly passive and 'looked-after' identity for the ill individual in his much-cited notion of the sick role[48]. Parsons argued that the sick individual is granted certain privileges, such as exemption from usual duties; with the obligation that he or she will seek competent help, trust the doctor and comply with treatment. The doctor is granted the privileges of professional dominance providing he or she is competent and knowledgeable, fulfils the obligation to act with beneficence, and follows certain conventions of professional conduct. This image prevailed unchallenged for a generation, but sits oddly against contemporary notions of empowerment[4,49–54], enablement[55], patient choice[56], patient-centredness[4], partnership[57,58], mutuality and reciprocity[25,59], and the challenging images and metaphors created by disability rights campaigners[60] and patient-led pressure groups[61].

In the 1970s, French philosopher Michel Foucault, whose work was influenced by the wider philosophical discourse around the constraining influences of language, published a radically new perspective on the medical encounter[62]. In 'Birth of the Clinic', Foucault distinguished two meanings for the word 'clinic': (a) the physical space of the archetypal teaching hospital, which emerged as an institution in the 19th century; and (b) the medicine practised within it and the ideas and meaning-systems that underpin that practice. The clinic (originally in French, *la clinique*) is no longer simply a roof over the heads of doctor and patient. It is a system of thought, a set of permitted and unpermitted words and expressions which articulates the human experience of being unwell and which, crucially, excludes from the doctor–patient discourse those parts of the encounter with which the new language cannot deal[62].

A similar socio-historical perspective on the theme of medical power, also from the 1970s, was put forward by Nick Jewson. His accounts of the changing doctor–patient relationship from the 18th century to the late 19th describe a transition from a 'customer–patron' relationship—accommodating to the needs of individual clients—to a more abstract and paternalistic relationship as health care became increasingly institutionalized[63,64]. Modern-day healthism may be seen as a reaction to the "disappearance of the sick man" that Jewson identified—a return to a world of client-identified needs.

Psychologist Eliot Mishler has re-interpreted Foucault's theories of medical power and language from a narrative perspective. He has argued that the physical setting of the clinical encounter has a powerful influence on the nature and course of the patient's narrative, chiefly

because the consulting room is the professional's 'space', and as such is the backdrop for a professionally-driven agenda, characterized by profound power imbalances between health professional and patient[65]. Launer points out that, for instance, the professional is in charge of time and even of when and in what way the patient gets seen at all[66]. Empirical research supports these observations: in the overwhelming majority of doctor–patient encounters, it is the doctor, not the patient, who asks most of the questions and who decides that the consultation is finished[67].

Patient empowerment is a popular theme in both government policy[68,69] and the health services research literature[4,49–54]. Indeed, randomized controlled trials have demonstrated the value of promoting patient empowerment in terms of objective measures of health status[49]. The term 'empowerment' generally has positive connotations of patients (typically from disadvantaged groups) being explicitly supported to ask questions, seek information, share decision making and so on[50–54]. But as our vignettes illustrate, the down side of empowerment can be demanding and manipulative behaviour by individuals for whom 'health for me' takes precedence over any notions of equity, fairness or citizenship.

Exploring the nature of 'empowerment' in the articulate middle classes has, perhaps understandably, not been a popular topic for research. As part of a wider survey of health beliefs and behaviour in 2248 respondents, Alberts *et al* compared well-educated and 'proto-professionalized' classes (that is, lay people who attempt to adopt the insights, beliefs and standards of medical professionals) and with a group from lower socio-economic backgrounds[70]. The former groups were less likely to seek care for everyday symptoms, but more likely to purchase over the counter medication, suggesting lower dependence on professionals and greater self-care for this type of condition. For more serious conditions, the differences in help-seeking behavior disappeared: for most of the chronic conditions studied, the well-educated and proto-professionalized individuals were just as likely to seek professional treatment as the less advantaged groups. However, for comparable symptoms they were more likely to receive specialist treatment, presumably because they were better equipped to persuade GPs to refer. This study lends support to the argument that one adverse spin-off of patient empowerment may be a widening of the gap between rich and poor (and, specifically, the information-rich and information-poor) in their ability to access specialist care.

The axis of healthism: 'nice' *versus* 'nasty'

As the fictional vignettes illustrate, healthism is often (though not invariably) characterized by a naïve faith in the benefits of certain substances

and an unshakeable aversion to others. It is broadly the case that anything 'natural', alternative, artistic, mystical or holistic is endowed with positive qualities whilst anything scientific, technical (especially artificially engineered or modified) is berated and feared. Medical anthropologist Cecil Helman, writing in a book published by the London Science Museum entitled 'Treat yourself: Health consumerism in a medical age' explains healthism in terms of the rise and fall of public confidence in the ability of science to dominate over nature. He argues:

"Until the middle of the last century, nature was prized for its healing properties—hence the popularity of mountain sanatoria and spas, where patients could benefit from the curing powers of fresh alpine air or mineral water. In the 1970s . . . the opposite was true: nature had become a threat. People were exhorted to keep it at bay, to protect themselves from the elements. In the new model, nature has come full circle and is once again valued as a positive, health-giving force (at least among the middle classes)"[7].

The simplistic dualism of 'nice, gentle nature' *versus* 'nasty, artificial science' may have real health risks, especially when capitalized upon by quacks and charlatans. The website of the US pressure group the National Association Against Health Fraud (www.ncahf.org/index.html) makes sobering reading—telling, for example, of a diabetic child who died after a herbalist replaced insulin with more 'natural' therapy (the herbalist, incidentally, was sentenced to 3 years in prison); a 10-year-old girl who suffocated during a 'rebirthing' ritual in which blankets were wrapped tightly around her to simulate a womb; and the 'natural' medication promoted as a pre-operative tonic which is hepatotoxic and significantly prolongs clotting time.

We found little formal research into the beliefs and perceptions of the educated middle-classes in relation to this phenomenon. But it is well described in the book 'Snake Oil' by investigative journalist John Diamond[71]. After announcing in his weekly newspaper column that he was himself suffering from extensive cancer, Diamond received hundreds of letters from readers, exhorting him to reject conventional chemotherapy and describing 'miracle cures' from various herbs, nutritional supplements and mystical treatments. He was struck by the uncritical faith in 'anything that grows out of the ground' and irrational fear of 'anything produced in a lab', especially since despite inviting readers to send in detailed reports, he did not find a single claim that was substantiated. At the same time, he explicitly linked this pro 'natural' agenda to an anti medical agenda, memorably describing the letters that he received under the heading 'Why your Doctor Hates You and Wants You to Die'.

The idea of a clear dichotomy between 'nice' and 'nasty' extends into the concept of boundaries, purity and the body. Anthropologist Mary Douglas has argued that the notion of purity is present in all societies but takes different cultural expressions[72]. During the mid 20th century,

prevailing western folk models of vulnerability placed the boundary to the body on its surface; 'germs' and 'chills' penetrated *via* unprotected body parts (abrasions, wet hair, bare feet on a cold surface, and so on). A corresponding folk healing industry arose around rituals of disinfection of the body's surface and its immediate surroundings. But, as Martin has elegantly described, the metaphor of vulnerability began to change in the last decades of the last century. The 'boundary' became more internal, and in particular a symbolic role was accorded to immunity and the immune system. 'Disinfection' (of the external body) was replaced by 'detoxification' (of its internal passages and humours). Clearly the rise of HIV/AIDS was one potent cause of this shift in emphasis, but the immune system provided a host of other secular metaphors that have been incorporated into health related beliefs[73].

For example, whilst the scientific literature linking stress and the immune system remains speculative (stress affects immune parameters, but there is relatively little evidence that this affects any disease outcomes), the link has become firmly established in popular thinking. Likewise, when we look at the remarkable rise of so-called 'illnesses of modernity', reflecting both the success of 'green' politics and a general cultural concern with the threat both from and to our environment[74,75], one of the themes that link seemingly disparate entities such as is the alleged involvement of the immune system. Silicon breast implants, dental amalgam fillings, electromagnetic sources, over refined food and many others are all believed to alter, poison or deplete the immune system, whilst the common features underlying popular explanations of conditions such as chronic fatigue syndrome, chronic candidiasis, multiple chemical sensitivity, food intolerances and so on, are likewise *via* the immune system. A few decades ago, many of these conditions were more likely to be explained by reference to the endocrine system—spontaneous hypoglycaemia being the prime example[76]—but the prevailing folk models have moved on.

These new 'illnesses of modernity' play a large part in what we call the culture of health. This is because although technically the pathogenic effects of hazards such as organophosphate pesticides, exhaust pollution, dental amalgam, electromagnetic radiation, food additives and so on, are all different, from the cultural perspective there are numerous overlaps. All have similar political dimensions, as part of a general concern (post Silent Spring, Bhopal, Seveso and Chernobyl) with the perceived deteriorating quality of our environment. And as health psychologist Keith Petrie has shown, these belief domains overlap—hence if you are concerned about the hazards of organophosphate pesticides, you are also more likely to be concerned about GM foods, or mobile phone masts, even though the risks of each are different in their presumed mechanisms[75].

Furthermore, the ways in which people manage these hazards on a personal level overlap and link with the cultural beliefs we have outlined. One way is to remove oneself from the hazard—but the tragic stories of those labelled with '20th century allergy' show that this is not possible. Another is to remove the hazard from oneself—as in those individuals who spend considerable sums having their dental amalgam removed for little measurable benefit except to the finances of the dentists concerned, but few take such drastic measures. A more common approach is to attempt to restore purity and remove 'toxicity'. Improving one's diet by removing additives, seeking out more natural products and dealing with intolerances has been advocated not merely for particular food allergies or intolerances but more generally for a host of other conditions including myalgic encephalomyelitis, chronic fatigue syndrome, candidiasis, stress and others. At the same time 'detoxification' (which has nothing to do with the medical intervention of the same name in relation to drugs of addiction) is sought variously *via* nutritional supplements, spa and herbal treatments, sauna and steam therapy, purging, skin defoliation, and inhalation of various aromatic agents[35]. All of this is aptly parodied in the *reductio ad absurdum* world of the popular TV soap 'Absolutely Fabulous', in which middle-class stereotypes pursue these cultural themes.

Conclusion

Healthism is a well-recognized socio-cultural phenomenon in the western (and westernized) middle classes, characterized by high health awareness and expectations, information-seeking, self-reflection, high expectations, distrust of doctors and scientists, healthy and often 'alternative' lifestyle choices, and a tendency to explain illness in terms of folk models of invisible germ-like agents and malevolent science. The healthism phenomenon probably arises from a number of different demographic, economic, technological, scientific and ideological forces—including what has been aptly termed 'the post-modern condition'. Healthism in the consultation is often associated with a poor (or at least, challenging) professional–patient relationship, and is a common source of irritation and stress to health professionals. It is surprisingly poorly researched, but nonetheless important since it has the potential to distort health care provision and effect unnecessary investigations and treatments.

In this chapter, we have attempted to explain healthism in terms of a composite theoretical model that incorporates Maslow's hierarchy of needs and theory of motivation; the notion of the reflexive, rational self; theories of power relations in the consultation; and prevailing folk models of chronic illness and weakness (including the secular metaphors of 'toxicity'

and 'immunodeficiency'). Whilst many of the drivers behind our modern culture of health and well being are beyond the scope of medicine, health professionals need to be aware of the healthism phenomenon if they are to understand patient concerns, avoid medical encounters unsatisfactory for both parties, and make the best use of limited resources.

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