

Inter-capitalistic disputes, biomedicalization and hegemonic medical model

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This paper is situated on the field of study of the working/productive process and the technological transition in health care. It examines the entrance of financial capital groups in the health sector and their struggles with the medical-industrial complex. It puts forward a comprehension of how the capitalist sectors, leaders of the restructuration of the working process in health, bet on the power of the creation of new subjectivities in order to transform and consolidate the current hegemonic medical model and the production/reproduction of the ways of the capitalism's agency role. We use the concept of biomedicalization to understand a radical stage of medicalization, a commonly used concept, albeit insufficient to understand the observed changes. The comprehension of these phenomena allows the recognition of resistances and "lines of flight" that could allow for non-mercantilist options in health, which may create autonomy and reinforce the value of individual and collective life.

Keywords: Medical-industrial-financial complex. Hegemonic medical model. Biomedicalization. Resistances and creation of new subjectivities. Market and health.

Introduction

Public debates and regulatory policies related to health sector reforms revolve predominantly around financing, cost control, and cost-effectiveness. The reforms under debate and those implemented are variations of health insurance or social security models based on public, private or mixed financing, as well as regarding who are those managing these funds and providing services (government agencies, private administrators or mixed forms). The roles of the various actors in the definition of health care models are scarcely analyzed, despite the fact that these roles determine the conceptualization of the health-illness-care process and therefore, the type of individual care and collective health programs implemented, who are the providers, how these programs and services are funded, and which are the populations served.

There are exceptions and perhaps the most notorious ones comes from the Brazilian studies analyzing the process of producing health care and its technological transition, emphasizing the effects on the creation of new subjectivities related to the health-illness-care process.¹ Many of these analyzes focus on the role of health care workers in their capacity to produce living work in act, which can generate new forms of caring for individuals and groups, or its opposite, to deepen capitalistic forms when producing medical and public health interventions. These analyzes, as well as our research on the financialization of the health sector, operating since the 1980s, which has resulted in the formation of the medical-industrial-financial complex, serve as a framework for this article.² The formation of the medical-industrial-financial complex refers to the penetration of the financial capital as an administrator not only of medical insurance, but also of health care services (hospitals, dialysis centers, home care services, diagnostic and treatment centers, emergency services, among others). This process is highly developed in the United States (US), and present in some Latin American countries. From that point, we deepen the understanding of how the capitalist sectors that are hegemonic in restructuring the production of health care, i.e., groups linked to the financial capital and to the medical-industrial complex, especially pharmaceutical companies, have focused their strategies on the power that the processes of creation of new subjectivities in health have in the transformation and consolidation of the current hegemonic medical model to reproduce

capitalistic agency processes.^{1,3} From the understanding of these phenomena and with the goal of counterbalancing the mercantilist strategies in health, we highlight the need of developing studies to analyze ongoing processes that open lines of flight and situations that de-territorialize the hegemonic medical model.

Concepts and methods

The analysis that we use in this study follows an analytical approach that proposes the reinterpretation of studies developed by the authors and colleagues related to the reforms that the medical-industrial-financial complex has been developing during the last 20 years.^(c) Our studies on the reforms that financial capital developed under the concept of managed care have been seminal in developing evidence on the strategies that financial groups used to control health care providers with the aim of reducing expenses and turning health care into a market commodity. These studies showed the ideological mechanisms and practices developed by groups linked to the financial capital and to the international cooperation and financial agencies (WHO, World Bank, among others) to change the common sense about the health-illness-care process, including the idea that patients/users should be transformed into clients/consumers. Part of the shift in the collective common sense was focused on presenting health care fund managers as smart buyers, able to rationalize excessive consumption, negotiate prices and coordinate health care, and increasing quality while reducing costs.²

These objectives required the control of the main actors stimulating the demand, i.e. health care providers (health practitioners and diagnostic and treatment service providers) and producers of goods and services in the health sector, especially pharmaceuticals and medical technology companies. During the analysis of these processes, new questions emerged in relation to what would be the answer, by those who historically defined the demand in health when confronted with the objective of financial capital to limit consumption. To answer these questions we use theoretical concepts and methodological

(c) Due to space limits, we will only cite the main references of all of those used in the analysis. Interested readers may feel free to contact the authors to ask for a complete reference list.

approaches encompassed by the Foucauldian meaning of "toolboxes". This resulted in the use of concepts and methods from different approaches, in particular those that do not intend to arrive at totalizing explanations resulting in new monolithic truths about the studied situation. In that direction we use concepts with proven analytical power in other of our studies, such as common sense and silent reform, as well as concepts in the field of the micropolitics of the health care work. We also use the concept of biomedicalization, for its potential to find new meanings for the analyzed situation.⁴

We found various methodological approaches to be useful in order to create a dialogue between different data sources. Two were the most important for the analyzes presented here: a) situational analysis, which provides elements to map different social actors and discourses, and b) discourse analysis used as a deconstructive reading and interpretation of power relations and their effects on creation of new subjectivities.⁵ The objective was to connect processes that appear to be disconnected in the speeches of the most powerful health sector actors, namely the medical–industrial complex and the financial groups.

The concept of power is hereby understood as multiple forces relationally operating in a determined situation and time. This concept is used in relation to the concept of governmentality in the sense of forces that operate strategically to create new subjectivities on the logics of governing the productions of lives, both individually and collectively.⁶ Our main idea was to understand the strategies of the pharmaceutical industry to confront the advances of the financial capital. In that sense, a first step was to observe the inter–capitalistic disputes, as a power confrontation between the medical–industrial complex and the financial groups that operate in the health sector regarding market share and the hegemony in defining the health–illness–care process. For this, it was important to analyze whether the pharmaceutical industry had developed strategies to change regulations in order to impact the organization of the health sector and the conceptualization of the health–illness–care process, favoring its position to regaining leadership in the health market and in creating new subjectivities.

First, we developed a non–systematic data collection, which we analyzed following the ethnographic method of observing and analyzing data and information to describe the situation widely. Following Clarke, we define our study as a multi–situated investigation, in

the sense that we examine multiple types of sources, interrogating the data from a particular situation of interpellation.⁵ (p.165). The sources we used included scientific and journalistic publications, gray literature, and electronic dissemination lists. Another important source was the dissemination materials that US pharmaceutical companies send by regular mail to potential consumers of their products. These materials opened up new options for obtaining additional data, such as names of companies linked to the reforms promoted by the medical-industrial complex, individual and collective stakeholders linked to the situation, as well as the strategies driven by companies to impact the sectorial regulations.

An extensive preliminary analysis allowed us to understand that pharmaceutical companies were using in their benefit the strategy initiated by managed care organizations to transform patients/users into clients/consumers. From our preliminary analyzes we also understood that the pharmaceutical industry was pushing for silent reforms to reposition itself in the market. We decided that the line of analysis that would allow us a deeper and wider understanding of the process would be through the use of analytical dimensions that capture the reforms in which the pharmaceutical industry was involved and from which it benefited. We defined the following dimensions: the regulatory changes with the capacity to impact the approval and commercialization of medicines and medical technology; transformations in the definition and denomination of diseases; the modifications in the clinical protocols to favor the over-diagnosis of diseases, and the mechanisms used to promote the demand for clinical procedures and medicines.

Using these dimensions, we developed a systematic review of the scientific and gray literature and government and business documents to find data (both primary and secondary) that would describe changes in regulations, scientific protocols, and business models consistent with the concept of redefining users/patients as consumers. We also analyze dissemination brochures, websites of public health agencies, professional associations, and patients and consumers' associations, advertisements in television, magazines, and newspapers, among others. With all these materials we started a process of mapping out the information obtained in each category to describe the situation and the results that companies are getting by recreating the health consumer and radicalizing the medicalization. We follow the methodological procedures explained by Clarke in his book.

We refer those readers interested in understanding the analytical–operational processes to the aforementioned book, as their description would merit a specific article.⁵

As a result of this process we obtained an analytical description of the strategies implemented by the pharmaceutical industry and then we reinterpreted them in the light of the concepts of biomedicalization, hard, soft–hard and soft technologies, and of the clinic of bodies without organs.⁷ This reinterpretation allowed us to gain a larger understanding of the effects that the discourses that currently model the health sector have had in the creation of new subjectivities and biosocialities, some as part of the neoliberal discourse that institutes the medical–industrial–financial complex and others questioning it.

Repositioning the medical–industrial complex

As pointed out earlier, we have analyzed in several articles the health sector reform processes lead by financial capital that began in the US in the late 1980s and exported from there to other countries in the 1990s. In this article we synthesize the reforms that tend to modify the subjective agency processes of health providers and users, which are the product of the initial disputes and of the later regroupings between the medical–industrial complex and the financial capital. The process of penetration of financial capital in the health sector introduced new stakeholders, changes in the sector's regulation, and new models of insurance that directly impacted the administration and the provision of services. The massive entry of this type of capital and its logic in the health sector changed not only the rules of the game at the economic level, but also introduced changes in individual and collective subjectivities in relation to the concept of health–illness–care. Professional decisions were subordinated to that of system managers in order to maximize profits, limiting the use of services through the control of prescriptions and referrals –frequently hidden– as decisions based on what was called evidence–based medicine since the 1990's. Health professionals, service managers, and companies producing medicines and medical technology were impacted by managerial transformations. These processes clearly showed that the capitals operating in health undoubtedly understood that any effective change in the productive processes in health needed to impinge on the micropolitics of living work in act,

where the production of medical model is instituted, both in the public sector as in the private. The medical-industrial complex had already placed their bets on this fact, historically guiding the promotion of its products to physicians, privileged holders of the relationship with patients and, therefore, potential inducers of consumption and creators of new subjectivities in the production of health.

However, managed care organizations went a step further by not limiting their intervention to capture the living work in act of health professionals, but seeking to impact the creation of new subjectivities in health care users. For this, they captured the concept of health consumer, which in the sixties had been introduced by the consumer advocacy movements in the United States. Their communication strategies were designed to show the need for patients/users to become informed clients/consumers of the health care insurances and services offered, in order to make rational decisions in terms of cost/benefit. It should be noted that, despite the good intentions of progressive American movements, the concept of consumer is regressive in relation to the notion of user/citizen. The concept of consumer implies the possibility of exercising power from the act of purchase, while the notion of user/citizen exerts power through a conception of social rights.⁸

The interests of financial capital confronted with those of the medical-industrial complex during the initial years of managerial reforms. By the mid-1990s, large pharmaceutical and technology-producing corporations began to generate silent reforms to reposition themselves in the health market, seeking to redefine the health-illness-care model.³ These processes required new changes in the hegemonic medical model that radicalized the medicalization, redefined as biomedicalization.⁴ The medicalization involves the expansion of the diagnosis and medical treatment of situations previously not considered health problems, such as pregnancy and childbirth. Biomedicalization, on the other hand, implies the internalization of the need for self-control and surveillance by the individuals themselves, not necessarily requiring medical intervention. It is not only a matter of defining, detecting and treating morbid processes, but also of being informed and alert of potential risks and conditions that could lead to disease.

Thus the pharmaceutical industry in particular decided to put more products on the market, in most cases by minimally changing the composition of some medicines, to

broaden the range of conditions for which they could be prescribed.⁹ This was reinforced by the intervention of experts paid by the industry in scientific committees that redefined diagnoses and defined new nosological entities, frequently transforming risks into diseases. Professional associations also contribute to these processes to guarantee that insurance companies pay professionals treating certain conditions. At the end of the 1990s many of the so-called lifestyle problems began to be re-defined using the procedure of moving the normal curve to the left. This had been introduced by Rose in 1985 in the case of problems of environmental contamination or other similar risks, lowering, for example, the values at which the exposure to a certain chemical can affect health. This was intended to take precautions and protect more people exposed to environmental or chemical contamination.¹⁰ But applying this mechanism, lowering values or broadening the spectrum of symptoms to which risks and illnesses are defined implies that overnight, healthy people are considered ill or with risks and may receive a prescription. This happened in the US when the values of hypertension, cholesterol, overweight/obesity and diabetes were redefined in the late 1990s. This procedure implied that only in that country 140,630,000 people (75 percent of the adult population) could be diagnosed and treated for some of these diseases and risks.¹⁰ Similarly, redefining mental health disorders (depression, attention deficit disorder, autism, anxiety, among many others, both in children and adults) triggered the prevalence and consumption of drugs of dubious efficacy and in many cases iatrogenic.¹¹ Moreover, we need to add the intense diffusion of new drug treatments for problems such as male impotence, low female libido, osteoporosis, fibromyalgia, restless legs syndrome, premenstrual disorders, and many others.^{12,13} In the next section we will analyze the implications of the creation of new subjectivities through biomedicalization.

Capitalist strategies and biomedicalization

There were several strategies that the medical-industrial complex, and especially the pharmaceutical industry used to renew its influence in the definition of the hegemonic medical model and to capture the user/patient, redefined for their commercial strategies in client/consumer. Even though these strategies vary by country because of internal

regulations, examples are based in the US, which is where they were first developed and from where they were spread globally. Since the mid-1990s, the industry exerted great pressure to deregulate direct advertising of prescription drugs or other forms of dissemination; pressured to accelerate the approval and marketing of new drugs; penetrated the scientific bodies advising the drug control agencies, gaining influence in the decisions on the drugs that are approved and banned; penetrated the scientific-professional bodies responsible for defining clinical protocols and diagnostic manuals to influence the creation of new diseases, redefinition of others and establishing the treatments to be followed; co-opted patient and family associations to act as agents of propaganda for their products; and created new business modalities.^{3,11,14,15} Their central objective was to regain the ability to influence the subjective processes related to the health-illness-care process, through motivating consumer decisions, since the old strategy of influencing prescribers was limited by the managerial control of the insurance companies. But this strategy was not even limited to directing marketing strategies to the sick, but to sell drugs, procedures and equipment to the healthy. This is the most innovative process the industry has developed over the past twenty years. For this, as we saw above, they diversified the supply of medicines and technologies by producing new ones or redesigning others to cover potential risks and so-called lifestyle conditions. But what we think is more important and we want to highlight in this article are the mechanisms used to create a new subjectivity in the health-illness-care process.

To explain these processes we will use the concept of biomedicalization that we differentiate from that of medicalization, since while the latter focuses on disease, care, and rehabilitation, biomedicalization focuses on health as a moral mandate that internalizes self-control, surveillance and personal transformation. Biomedicalization implies the governmentality and regulation of individuals and populations through the reconstruction of the hegemonic discourse in the field of health, presented as the new scientific truth. With biomedicalization we move from a growing control of nature (the world around the subject) to the internalization of control and transformation of the subject and his environment, transforming the life itself.⁴

Other useful concepts to advance these analyses are those of hard, soft-hard and soft technologies that operate in the daily lives of the populations, facilitating that the interests linked to this biomedicalization trend may operate and institute their hegemony in the definition of the health-illness-care process.¹⁶ By hard technologies we understand, for the subject matter of this article and expressed in a very broad way, those equipment and technological devices for diagnosis and treatment used in health care services, but also medicines, small household devices and personal computers. By soft-hard technologies we understand the organized knowledge, and for the present approach, clinical protocols, questionnaires to identify conditions, advertisements and other instruments that encode discursively signs and symptoms. These soft-hard technologies enable users to assess their current or potential risk of suffering from one of the many pathologies defined by professional associations and national and international agencies, and even those that begin to circulate, although they have not yet been officially defined, but are pre-installed through the media and other communication mechanisms that facilitate the circulation of "scientific novelties". By soft technologies we understand those produced in the relational space between users and providers, companies selling health goods and services, scientific and/or professional associations, government agencies, etc., as well as among users and also with family and friends. All these relational processes take many forms, going beyond personal contacts; they are increasingly based on social networks, portals and other similar mechanisms, which are used to establish these "dialogues" and "relationships."

We will see below how they operate to build the hegemony of a medical model favoring a clinic of the body without organs, supposedly mastered by the patients. At the level of the hard technologies there were two processes instituting the biomedicalization process lead by the medical pharmaceutical and medical technology industry. On the one hand, appeared the possibility of mass consumption of biotechnologies, including medicines, diagnostic tools and other equipment. This is the case of the access to low-cost devices to monitor blood pressure, blood glucose, pulse and oxygen, among a variety of other equipment now available to use at home. On the other hand, the developments in computing and communications, which are hard technologies that facilitated the development and penetration of soft-hard technologies, allow the capture of huge amounts of health data

from individuals and populations by corporations, as well as the massive dissemination of information on diseases, conditions and risks, and ways to detect, treat and prevent them. Examples of these processes include the creation of public websites developed by companies that are often subsidiaries of pharmaceutical companies. These websites (soft-hard technologies) invite users to a virtual dialogue and “relationship” by proposing the introduction of their clinical parameters, the drugs they consume, and treatments they follow, among other data. The stated purpose of these websites is to help people to control their health, reminding them to consulting the doctor, when to check vital signs and biological parameters, taking the prescribed medications, proposing questions to ask in the consultation, etc. On the one hand, these soft technologies shape the subjectivity of users who focus on certain processes and not others, and feel empowered in the management of their health problem without the professionals. An important goal of corporations is to capture enormous amounts of information that they use to produce increasingly precise communicational/relational marketing strategies to target specific social and age groups, among other categories. The technologies considered “hard” for the purposes of this analysis are computers and Internet, which facilitate the dissemination of the use of medicines and their purchase, bypassing in many cases the national regulations. Websites and other media means (magazines, cable channels, closed circuits of television in hospitals, and others) are utilized to disseminate detailed information on conditions and treatments. Concise questionnaires are made available to health professionals and patients to assess current or potential risks of suffering from any of the described conditions.

These phenomena facilitated the creation of new processes of subjectivation, identities and biosocialities around the health-illness-care process. Social networks dedicated to health issues occupy a prominent place in the construction of soft technologies. Real patients and/or family members have created some of these networks, but others were developed by the pharmaceutical industry or by scientific associations dedicated to specific health problems (Diabetes Association, Heart Association, etc.). Many of these groups have been co-opted by the pharmaceutical and technology industries, through the financial support they provide.¹⁵ These networks create strong identification links in which users begin to define themselves or their family members according to the health problem that

affect them or they believe that affect them. Patients as consumers are active subjects of the process of biomedicalization and not just passive consumers.

This clinic of the body without organs and its correlates at a collective level in the so-called new public health, have developed illusory discourses according to which young and energetic body and mind can be maintained by taking strict control over the risks that threaten them, especially those related to lifestyles. This discourse is accompanied by an intense dissemination of the "needed knowledge" via the new communication tools to access it and share it with family and friends. National and international public health organizations are part of this strategy that promotes the biomedicalization of the health promotion and prevention.¹¹The Centers for Disease Control and Prevention (CDC) on its website offer users, both Anglo and Spanish speakers, information on various diseases and conditions, communication tools to disseminate information between family and friends, and information on how to pre-diagnose various health problems. The health topics are multiple, attention deficit and hyperactivity, overweight and obesity, autism, chronic fatigue syndrome, among others. Also, from the CDC website, people are able to connect directly with numerous patient and family associations, which provide more direct information about medications, types of treatments and names of specialized practitioners. Internet and communication technological advances are key tools to facilitate the radicalization of medicalization, allowing corporations and public health agencies to segment communication strategies by age, gender, nationality, culture, pathology, risk, etc. These technologies make it easy to reach people through various media means according to the targeted group, i.e. personal computers, tablets, cell phones, television, radio, etc. as well as using various communicational mechanisms, such as websites, social networks, or others.

The messages on health-illness-care are presented as moral mandates, stating that if individuals do not proactively control their health, the results of their behaviors create an economic burden for the rest of society. This goes beyond using medical interventions to recover health affected by diseases or conditions, and also entails the biomedicalization of prevention and promotion through the internalization of the moral mandate to remain healthy and exerts practices of health surveillance at the individual level.¹⁷ Being healthy in the context of biomedicalization means that it is an individual responsibility to control

potential diseases and conditions with analytical laboratory, genetic or other tests and to consume drugs, medical devices and other biotechnological products and services. Instruments offered to comply with this moral mandate include tools via the Internet and other communicational mechanisms that provide information through the privacy of personal computers, home entertainment devices and cell phones, or are disseminated in other everyday spaces such as schools or work places. Under the assumption of risk control, people are educated about diseases and conditions, as well as how to diagnose and control them, such as the case of blood pressure or glucose levels using household equipment and promoting the consumption of medicines.¹⁸

In the context of biomedicalization, health professionals in their traditional role as leaders of the care process are more and more dispensable due to the new business model developed by the medical-industrial complex.³ As we pointed out earlier, the process includes transforming patients into active consumers entitled to receive information from other sources and take care of their own health, even consuming products without the intervention of a prescriber. The industry has also developed new soft technologies, as part of this new direct relationship with its potential consumers, to teach them how to influence doctors and other health professionals to prescribe the "desired product"¹⁹. Youngsters are especially vulnerable to such messages that promote self-prescription.

New scenarios and their consequences

Disputes over the hegemony of the health sector between financial capital and the medical-industrial complex have profoundly transformed the sector. The powerful competitors (financial and industrial capital) gained a share in the allocation of market and profits. Rights-based public health care systems, employer-based medical insurance, health care service providers and, above all, the population are affected by these disputes, which led to deepening the commodification of health. Financial corporations that manage medical plans and health care services have developed agreements with the medical-industrial complex to use their products and services receiving discounts not available to the public.³ These agreements favor the use of treatments based on medicines and other technological

developments that may not represent the best available option for patients. Using subtle mechanisms that present the information as objective and created to empower patients, actually converted them in consumers exposed to the biomedicalization of their lives. Regulatory agencies in all countries are far behind in their ability to regulate the multinational corporations activities of data mining and direct to consumer communications.

In principle, more access to health information should be considered democratic and welcome; however, the problem lies in who are those involved in developing the information, how it is generated, and what are the interests behind it. Likewise, the process of commodification of the production and circulation of health information requires the consideration that its access is stratified, differentially affecting social groups and countries. Providing information to prevent disease is not itself the problem, but rather the fact that it occurs in the context of the expansion of neoliberal policies and the extreme commodification of the health promotion and prevention.²⁰ The enlargement of the concept of prevention is more and more on the side of clinical care focusing on individuals, in a clinic of the body without organs and hyper-commercialized. The concept of risk is a clear example of this process, since it went from being used to account for population risks, then to be used to characterize individual risks, which paradoxically have been positioned subjectively as diseases, especially those for which there are medications available (cholesterolemia , hypertension, among others).¹⁰ The concept of preclinical conditions (pre-hypertension, pre-diabetes, etc.) was installed following this line of reasoning, often only generating iatrogenesis, suffering and more medical interventions.¹⁴

The most disadvantaged sectors of our societies also receive these messages that reinforce the moral mandate to control their health in order to avoid being a burden for the larger society. For these groups information is disseminated through schools, health fairs, other public events, and particularly through the media, especially television, in programs dedicated to women, in news programs and even through cable channels fully dedicated to health issues. Well-intentioned public health practitioners also reproduce this conception of health-illness-care and implement these communicational mechanisms without understanding, most of the time, how they operate and what are their consequences. People are encouraged to use their limited financial resources to control cholesterol, blood

pressure, glucose, and other conditions, and to seek treatments (conventional or alternative) to control the risk of becoming ill. However, as health statistics show, the most deprived sectors of our societies "fail" to achieve the health outcomes of the most privileged classes. Instead these groups must also feel guilty of not eating healthy, not doing sufficient physical activities and suffering from stress due to socioeconomic situations out of their control.

Health professionals and workers are also affected in their capacity to offer health care services non-based on a commercialized and a population control conceptualization. These approaches seek to frighten people against the potential risks of becoming ill or dying, or not complying with the aesthetic values of a culture based on success, physical appearance, youth, consumerism of ephemeral objects and high intellectual and physical performance. Health professionals often feel constrained to follow mandates on how to treat patients because the imposition of clinical protocols and so-called evidence-based medicine and/or because the fear of being compared to those professionals who apply treatments that are in line with what people heard to be the most advanced ones. This is aggravated by time constraints –given the pressure exerted by financial goals or quantitative labor productivity– to explain to patients why the treatment they request is not appropriate for their health problems. Clearly this is a situation that affects both, users and health care providers, but it is also a situation that we all have the possibility to question and transform.

Betting on the potentialities

Our goal for writing this article was, on the one hand, to analyze these processes that many people live in daily bases, but fragmentally. For this reason, it is difficult to elucidate their causes and connections, as well as the social actors who are involved and the role that hidden interests are playing. On the other hand, we expect health professionals to understand the power of having the possibility of developing a relationship with patients under the idea of the living work in act.¹⁶ In our work with health workers in different countries, it is common to hear that they do not want to be mere prescribers of actions defined by others. They question the exploitation by the financial managers of the system, and that they see diminished effectiveness in their interventions. Patients complain because

the limited time of the clinical encounters, that health professionals do not listening then, and the lack of resolution of their health problems. Here we observe a potential for a majority movement of rebellion against a medical model that does not generate satisfactory working conditions, which is increasingly less scientifically grounded and shows limited effectiveness in the fight against many conditions affecting the majorities. We thus invite to investigate and exchange current experiences related to the lines of flight that constantly appear in the daily practices of health care services, looking for de-territorializing situations of the hegemonic medical model that seek to de-commercialize and de-medicalize health experiences.

Contribution

Celia Iriart conceived the initial idea of the present analysis, prepared the first draft, edited and approved the final version; Emerson Elias Merhy contributed with the analysis, edited the first draft, revised and approved the final version.

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