The Unsung Virtue of Ambivalence in Advocacy

FROM BOTH SIDES NOW

People who have had cancer know why we need advocacy. When we hear about lengthy waiting lists for diagnostic tests and for treatments and recall the anxiety we once felt, knowing something was destroying our bodies and every day's delay furthered that destruction, we know advocacy is necessary. When we wonder whether the treatments that cancer patients are receiving are clinically proven to be the best, or whether they are simply the most economical for provincial budgets, we know advocacy is necessary. And when we see people with cancer and their families being stigmatized and discriminated against in workplaces, we know we need advocacy. But if advocacy does not move beyond being more than a shopping list for cancer patients, there will be as much unnecessary suffering at the end of these efforts as there was at the beginning. Indignation is refreshing in its apparent clarity. What causes suffering is often less than clear. Here are three examples.

1. Bandwagon Campaigns

A major achievement of advocates has been their participation in health promotion campaigns to convince people of the dangers of tobacco smoke, the sun, poor nutrition, and industrial toxins—to name only four. Non-smoking bylaws are saving lives. Yet these campaigns depend on the dangerous half-truth that people cause their own cancers by their chosen "lifestyles."

What's dangerous is increasing social acceptance of the idea that cancer is a disease that individuals can prevent for themselves. By this logic, people who have cancer become failures of prevention. But breast cancer and prostate cancer have no lifestyle causes. If all the lung cancers caused by smoking were eliminated, lung cancer would still remain a major form of cancer. The half-truth that individual behaviour can prevent cancer not only stigmatizes those whose cancer could not be prevented, it also distracts public attention from environmental causes of cancer that individuals have no control over: the ozone layer is literally the biggest example. Advocacy needs health promotion, but health promotion needs to call attention to its own limits.

2. The Shopping List Syndrome

A second reason for ambivalence is advocacy of new technologies for cancer care, including both diagnostic machinery and pharmaceuticals. When industry both offers funding for advocacy and promises treatment advances, it's easy to forget that what has been accurately called the medical industrial complex wants to use advocates to increase the demand for their products. The deeper problem is what I called advocacy as shopping list: the conviction that if more money were spent, problems would disappear. Some problems like waiting lists do call for more money. But advocacy also needs to recognize when "more" does not relieve suffering. Decision-makers prefer to invest in technology rather than in people who give hands-on care. Technology reinforces the tendency to locate every

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hope in a material form and to seek every desire in some commodity that people are able to buy, or not, according to their resources.

The coming crisis of health care has created two opposing camps. The one side believes that medical services represent the obligation of a community to respond to those who suffer. On the other side is the every-man-for-himself attitude, reflected in the response of an anesthesiologist to one of his colleagues denying a standard form of anesthesia to a woman in labour because she could not pay an illegal extra-billing fee. "Poor people can't expect to drive a Rolls-Royce," he said, "so why should they expect to receive the Cadillac of analgesics for free?" That view was immediately denounced by the physician's professional association, but the attitude it expresses may not be so unusual. The increase in private health-care facilities in Alberta and queue-jumping by privately insured patients in Ontario illustrate a "drive what you can afford to drive" mentality.

3. The Temptation to "Throw the Baby Out With the Bath Water"

The threat of health care becoming a commodity leads to my third ambivalence. Repeated emphasis on the inadequacies of health-care provision in Canada reinforce an attitude that the Canada Health Act is unworkable, which in turn supports a sense that greater privatization—the American model—is inevitable. Here is a central dilemma: How can we advocate for the best cancer care without undercutting a delivery system that is among the most equitable in the world, infinitely less bureaucratically draining for patients, and cheaper for everyone? Indignation fuels advocacy but tends to ignore the dilemmas of health promotion, technology, and how to support the system we advocate within. Advocates thrive on being definitive, but in the complex world of health care, ambivalence can be a virtue. ◆

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