

In medicine, more is not always better. The case of prevention (and prediabetes)

En medicina, más no suele ser equivalente a mejor. El caso de la prevención (y de la prediabetes)

Na medicina, mais nem sempre significa melhor. O caso da prevenção (e da prédiabetes)

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Abstract

Health is a social construct, and maintaining or improving it requires an intersectoral approach, something like “Health in All Policies.” Medical interventions are frequently overvalued, perhaps due to their dramatic nature and effectiveness, which can sometimes appear almost miraculous, such as the appropriate use of medication to ease pain during the dying process. However, overall health depends more on social conditions than on medical care, and it is essential to understand that more medicine does not necessarily mean better health. In fact, physicians should be kept at a distance, especially in the realm of prevention. Driven by a preventive zeal, healthcare professionals may unintentionally cause harm by promoting a form of “health tyranny”: interventions lacking both scientific evidence and ethical grounding. One example is the proliferation of “predisease” categories such as preosteoporosis, prediabetes, or preobesity, which pathologize healthy individuals under the illusion of avoiding future illness. Prevention is not always better than cure, and above all, we must recognize that preventive interventions can also produce adverse effects.

Keywords: Quality of life, science of science, science and society, medical sciences, ethics of science, social factors, preventive medicine, critical thinking, prediabetes.

Resumen

La salud es un producto social, y para mantenerla y mejorarla, es imprescindible la aproximación intersectorial, “la salud en todas las políticas”. Las intervenciones sanitarias se suelen valorar en exceso, quizá por su espectacularidad, y efectividad, que a veces las hace casi milagrosas; por ejemplo, el uso razonable de medicamentos que ayudan en la agonía, y a morir sin dolor. Pero, en

general, la salud depende más de la sociedad, que, de los médicos, y conviene saber que más medicina no equivale a más salud, por lo que hay que mantener alejados a los médicos, especialmente en el campo de la prevención. En su “afán preventivo,” los médicos pueden llegar a causar mucho daño al promover una “tiranía de la salud” sin ciencia, ni ética, sin límites. Por ejemplo, con las definiciones de preenfemedades, tipo preosteoporosis, prediabetes, o preobesidad, que transforman a sanos, en enfermos, con la ilusión de evitar males mayores. Prevenir no es siempre mejor que curar, y sobre todo conviene ser conscientes de que las actividades preventivas también tienen efectos adversos.

Palabras clave: Calidad de vida, ciencia de la ciencia, ciencia y sociedad, ciencias médicas, ética de la ciencia, factor social, medicina preventiva, pensamiento crítico, prediabetes.

Resumo

A saúde é uma construção social e, para mantê-la ou melhorá-la, é fundamental uma abordagem intersetorial -o que se conhece como “Saúde em Todas as Políticas”. As intervenções médicas costumam ser supervalorizadas, talvez por sua natureza espetacular e aparente eficácia, que por vezes chega a parecer milagrosa -como o uso adequado de medicamentos que aliviam a dor no processo de morrer. No entanto, em termos gerais, a saúde depende mais das condições sociais do que da medicina, e é importante compreender que mais medicina não significa necessariamente mais saúde. Pelo contrário, convém manter certa distância dos médicos, sobretudo no campo da prevenção. Movidos por um zelo preventivo, profissionais de saúde podem acabar causando danos ao promover uma “tiranía da saúde” -com práticas sem respaldo científico nem ético, e sem limites claros. Um exemplo é a criação de categorias como pré-osteoporose, pré-diabetes ou pré-obesidade, que transformam pessoas saudáveis em doentes, sob a ilusão de evitar doenças futuras. Prevenir nem sempre é melhor do que curar, e é essencial estar ciente de que ações preventivas também podem ter efeitos adversos.

Palavras-chave: Qualidade de vida, ciência da ciência, ciência e sociedade, ciências médicas, ética da ciência, fatores sociais, medicina preventiva, pensamento crítico, pré-diabetes.

Introduction

Medicine is a blend of art, science, solidarity, and technology that helps humans live longer and with better quality of life... it often performs “secular miracles,” such as: (1) preventing the progression of skin cancer, through removal during a general practitioner’s consultation; (2) offering consolation to a widow, with the right words, following her husband’s death due to complications from a traumatic brain injury; (3) cataract surgery, restoring sight to an elderly patient; (4) an appendectomy preventing death from peritonitis in an adolescent girl; or (5) post-exposure rabies vaccination, preventing disease in a

caver bitten by an infected bat.

These “secular miracles” can be dazzling even to healthcare professionals themselves, who may develop Hubris Syndrome (arrogance with overconfidence; González, 2019) —a kind of self-deification that can make them dangerous. Likewise, society develops a dependency complex with Medicine, attributing to it only good. For instance, people tend to believe that the increase in life expectancy at birth is due to more Medicine, when in fact it results largely from improvements in social determinants: nutrition, education, housing, decent employment, wealth redistribution, and water sanitation systems.

It seems logical to assume that more Medicine leads to more health —especially when one operates within a seventeenth-century biological and scientific paradigm, and when health is treated as an end in itself rather than a means to enjoy life. As an analogy: drinking water is essential, and without it we die —but drinking excessive amounts of water can lead to illness and even death. Water intoxication has been used as a method of torture by forcing individuals to ingest extreme quantities (23 litres or more; Martínez, 2022). We want to believe that Medicine provides benefits without harm —but that is impossible, since all medical interventions carry the potential for adverse effects. In fact, the word *phármakon* in Greek means both remedy and poison. We also know that all screening procedures produce harm; some provide more benefit than harm, but only a few do so at a reasonable cost (Gray et al., 2008).

Even a single word or piece of advice can result in immense harm —as shown in the 1970s and 1980s when it was difficult to resist the pressure from paediatricians, the media, and family members promoting the absurd recommendation that babies sleep face-down to prevent sudden infant death syndrome (SIDS) (Gérvás & Pérez-Fernández, 2024). The sudden and unexpected death of a previously healthy infant is a traumatic event with profound effects on families and society, and it is thus avoided at all costs —even if the advice to do so is irrational. Unsurprisingly, most parents followed this recommendation in the belief that they were doing the best for their child —unknowingly accepting an increased risk of sudden death. In fact, the face-down sleeping recommendation had the opposite effect: it increased the incidence of SIDS fivefold (Jonge et al., 1989). Thousands of otherwise healthy babies died as a result. Despite early warnings from some professionals, it took nearly a quarter of a century for this harm to be officially acknowledged. Only then, in the 1990s, was it reversed through the Back to Sleep campaign.

When we work according to the principle of *primum non nocere* (“first, do no harm”)¹, the aim must be to ensure that the probable benefits of medical activity outweigh the uncertain harms—and that this balance is achieved at a reasonable cost. In other words, Medicine earns social trust only if its

¹ “*Primum non nocere*” means “first, do no harm” and expresses the ethical duty to avoid causing harm when intervening.

interventions produce a margin of benefit that significantly exceeds the margin of harm (Gérvás & Pérez-Fernández, 2022). In any case, the impact of medical care on overall health is marginal — approximately 10%; the remaining 90% comes from genetics and social conditions (Kaplan et al., 2019). For example, while necessary, the measles vaccine adds only 0.16 days of life expectancy in developed countries (Wright & Weinstein, 1998).

Impossible Clinical Promises Based on the Prevention of All Harm

From towers of arrogance built on foundations of ignorance (Gérvás & Pérez-Fernández, 2009; Gérvás, 2019), and with an authoritarian attitude, physicians often promise near-eternal youth — especially if their lifestyle and preventive recommendations are followed. Medicine transforms every adversity into disease and offers “remedies” to prevent all forms of harm, a pill for every problem. In doing so, Medicine adopts a moralising role, and falling ill becomes easily interpreted as the result of “sin” —specifically, the failure to follow preventive advice that now encompasses every aspect of life. For example, obesity is attributed to gluttony, syphilis to lust, diabetes to laziness, lung cancer to smoking, liver cirrhosis to alcoholism, AIDS to “vice,” anxiety to anger, and so on.

Medicine thus becomes a kind of religion, whose rituals are governed by doctors (and industries), imposing individual and population-level control over the body and over life—or over “sins.” This is what Foucault (2007) called biopolitics. The doctor, affected by the aforementioned Hubris Syndrome, becomes grandiose and arrogant, convinced of their uniqueness and immune to the suffering caused by their unscientific and unethical prescriptions. For instance, the paediatricians who caused the deaths of thousands of healthy infants by recommending face-down sleeping have never apologised (Gérvás & Pérez-Fernández, 2009).

In the realm of prevention, medical arrogance (Sackett, 2002) manifests as aggressively assertive prescribing —of changes, medications, and interventions, all issued without nuance or doubt. It is also presumptuous, assuming its own efficacy and benefits to be self-evident and unquestionable. And it is proud, attacking those who dare to challenge the value of its recommendations. The health system is no longer labelled one of “illness” but of “health,” and curative contracts -committed to suffering- are now replaced by preventive contracts —committed to the healthy. As a result, resources (especially professionals’ time) are “stolen” from those who need them most: the sick, the elderly, the poor, and the illiterate.

Prevention is deeply inequitable because it redirects resources toward those who are already most concerned about their health. In other words, it prioritises the healthy, the young, the affluent, and the university-educated —groups who, in fact, have the least need for medical care and already enjoy higher life expectancy (as well as more materially “secure” lives, including sufficient pensions in old age). It is easy to embrace lifestyle changes when one has money, cultural capital, and a long, fruitful

life expectancy (Gérvás & Pérez-Fernández, 2013). There is a future only where social conditions are good —and that future is sustained through activities aligned with such expectations. Many “risky” and “unhealthy” behaviours are rooted in populations with poor socioeconomic conditions (Irigoyen, 2020). Much of the money spent on prevention ends up benefiting the rich, the upper and middle classes. This reflects the inverse care law, which holds that those who need care the least often receive the most —and this law is especially true in systems leaning toward privatisation (Hart, 1971).

For example, smoking is a social and political issue that disproportionately affects the poor (Hitchman et al., 2014) —not merely a clinical or medical matter. The same is true of obesity, diabetes, and sedentary lifestyles: these, too, primarily affect the poor. The geography of obesity is the geography of poverty, clearly visible in the marginalised neighbourhoods of major cities (Ellen et al., 2025). Of course, individual clinical responses are important, but effective prevention requires intersectoral action and health policies across all domains. If we aim to promote public health, we must change people’s living conditions. Disease prevention is a social issue, because the causes of many diseases are themselves social (Gérvás & Pérez-Fernández, 2013).

Yet under the prevailing biological and medical model, what matters is prevention for its own sake—avoiding the need to respond to patient demands by anticipating them. Health through prevention, they say. As a result, clinical care for the sick is weakened. There is “no time” for what truly matters - like home care for chronically ill patients- and endless waiting lists are created, even in primary care.

The growing rhetoric around prevention is generating confusion —both individually and collectively. The culture of “risk avoidance” in life is provoking a conceptual shift in how medical care is defined and how medical needs are designated (Gérvás et al., 2008). Increasing emphasis is placed on “risk factors” located far upstream in the causal chain. Politicians, professionals, sociologists, and journalists often forget the prevention paradox described by Rose (2001), who warned that individual-level prevention must be carried out with “extreme caution.” Furthermore, the concept of “risk factor” is purely statistical —based on association, not causation. A risk factor is neither necessary nor sufficient to cause a disease. Yet in preventive medicine, statistical association is often confused with causality —an ambiguity that lies, quite “non-innocently,” at the heart of contemporary Medicine (García, 1998).

Too Much Prevention Harms Clinical Care

To save primary care from collapse, it is essential to curb the enthusiasm for minimally beneficial clinical preventive services in asymptomatic and low-risk populations, and to return or reassign responsibility for primary disease prevention to public health. Each new preventive activity or expansion of the target population represents an unacknowledged opportunity cost for primary care. Since time cannot increase proportionally, each additional preventive action should yield health outcomes that surpass the status quo of caring for sick patients. Yet preventive recommendations are

rarely (if ever) evaluated from this perspective. For instance, it has been estimated that primary care physicians in the United States would need 27 hours per working day to follow all the recommendations from guidelines and protocols —and more than half of that time would be spent on preventive interventions (Martin et al., 2025).

Medical supply generates social and individual demand. The idea is promoted that all discomfort is preventable, that perfect health is attainable —and to support this belief, inescapable fears are created. The demands become endless: eternal youth is pursued, and every illness is framed as a medical failure —either something that should have been avoided or that was caused by a lack of prevention (Gérvas & Pérez-Fernández, 2013). Medicine injects fear through its boundless prevention, risk factors, and “invented” diseases, and fear creates new needs -satisfied by new and old health goods and services- in a vicious cycle of dissatisfaction that always leads to greater consumption.

In clinical practice, this excessive expansion of prevention can lead physicians to reject clinical uncertainty, to feel aversion toward suffering patients (who are perceived as “at fault” for not preventing their illness), and to deny the persistence of disease —viewing chronic patients as people who “don’t want to heal” or “don’t follow medical advice.”

The truly ill patient, the one who suffers, who harbours fears that are difficult to explain, who deals with incurable or nearly incurable conditions, from obesity to anorexia, from osteoarthritis to coronary ischaemia, from diabetes to COPD -chronic obstructive pulmonary disease-, from Marfan syndrome (a hereditary disorder affecting connective tissue that can impact the heart, eyes, blood vessels, and skeleton), to idiopathic low back pain -back pain of unknown origin-, or the one who faces death close and in front... is no longer viewed as interesting or engaging patient.

In this context, some doctors may lose interest in daily clinical work -the same practice that once dignified their profession- and instead become “guardians of health,” thereby encroaching upon the domains and responsibilities of public health professionals and policymakers.

The efficiency of the healthcare system decreases when clinical doctors take on tasks that fall outside their remit —tasks that are more effective when implemented at the population level rather than the individual level (Gérvas and Pérez-Fernández, 2013).

Turning the Healthy into the Sick at the Altar of Prevention: The Case of Prediabetes

The turn toward prevention brings with it the obsession with avoiding even inevitable death —as if Medicine’s goal were to prevent the impossible (in fact, Medicine is not meant to prevent all deaths, only those considered “medically avoidable”). Likewise, it aspires to eliminate all suffering when, in reality, the aim of Medicine is not to avoid all pain and misfortune, but only that which is medically

preventable. For instance, the idea of a “world without pain” is being proposed and widely accepted, as though all pain, whether physical, psychological, or social, were avoidable. A society that falls into this trap allows doctors to become “dealers” and patients to become “addicts.” They sell paradise on Earth, but the result is hell—as demonstrated by the opioid epidemic in the United States, where hundreds of thousands have died from overdoses (CDC, 2024).

It is therefore wise not to attempt to prevent all pain, and to accept living with a certain “healthy” degree of suffering. Likewise, it is unwise to avoid all risk, for doing so would strip life of meaning. And we must accept certain obvious truths—such as the inevitable impact of aging and the certainty of death. Yet this society does little to curb the fantasy of eternal youth or the desire to escape all adversity. Consider, for example, type 2 diabetes—adult-onset, linked to obesity and sedentary lifestyles (and poverty). It is now “prevented” by defining a risk factor through a normative blood glucose value, beyond which a person is labelled “prediabetic” and subjected to various interventions to “prevent progression to type 2 diabetes.” In this way, a healthy person is turned into a sick one based on their “risk” of developing diabetes—using biometry, the normative classification of health through consensus-based metrics agreed upon by medical professionals.

Through biometry, millions of healthy people can be transformed into patients in a matter of hours. This is achieved, for instance, by lowering the thresholds for what is considered a normal cholesterol level, or by inventing new diagnostic categories such as prehypertension, pre-obesity, prediabetes, pre-osteoporosis, pre-dementia, or even pre-mortality (which, arguably, will soon become a profitable concept—since we are all “pre-mortal”).

This artificial increase in labelled patients diagnosed with “pre-” conditions entails multiple harms. First, labelling individuals as at-risk or diseased based solely on numbers or aberrant screenings can generate unnecessary fear and, in itself, harm health and well-being. Second, any expansion of diagnostic categories inevitably diverts care and resources away from those who are truly ill. Third, it risks making solidarity-based healthcare systems financially unsustainable due to escalating costs. Fourth, the focus on biotechnology marginalises and obscures the socioeconomic causes of poor health (Heath, 2013).

In the case of obesity, a new definition introduced in 2025 distinguishes “clinical obesity”—a state of chronic systemic disease caused directly by excess adiposity—from “preclinical obesity”—a state of excess adiposity without current organ dysfunction or daily limitations, but with higher future health risks (The Lancet Diabetes and Endocrinology, 2025a). In this case, neither obesity nor pre-obesity is inherently a disease or a problem—but the new definition paves the way to classify hundreds of millions as patients requiring medical care and pharmacological treatment.

Ironically, the risk factor known as prediabetes has its own set of risk factors: overweight and obesity,

age (45 and over), genetic predisposition, poor diet, physical inactivity, socioeconomic deprivation, and the presence or history of other conditions (such as metabolic dysfunction-associated fatty liver disease or gestational diabetes). Ethnicity is also a contributing factor, as Asian, Black, and Hispanic adults are at higher risk for prediabetes than those classified as White or non-Hispanic (Llanos et al., 2024).

This biometric logic -defining “pre-disease” as a risk factor that itself has risk factors presented as causes- reveals a new form of medical power: the authority to define health and illness by consensus (usually to the benefit of health industries, especially pharmaceutical companies) (Gérvas and Pérez-Fernández, 2006).

Furthermore, there is a growing trend toward over-definition, rooted in a routine technological, medical, and social attitude, that slowly and systematically undermines health. In reality, we know that type 2 diabetes is associated with “social harm” —for instance, with economic hardship, such as struggling to make ends meet (Escolar, 2009). The true “risk factor” is social -it is a condition of life, not a lifestyle choice- but that is of no interest to industry, nor to a Medicine increasingly oriented toward biology, nor even to public health officials or politicians. What drives the business is the medicalisation of life, biometry, and pharmacological treatment.

Literally: prediabetes can be treated or reversed through intensive lifestyle modification involving caloric restriction and increased physical activity —or, less effectively, with metformin in certain populations. In the 2024 STEP 10 trial, among people with obesity and prediabetes, 81% of those treated with semaglutide 2.4 mg reverted to normoglycaemia, compared with just 14% in the placebo group. This result suggests that GLP-1 receptor agonists could, in the future, offer hope to individuals for whom lifestyle changes have failed. Prediabetes is framed as the final threshold in the glycaemic spectrum where type 2 diabetes can still be stopped (McGowan et al., 2024).

However, for a long time, it was considered merely a risk factor, rather than a critical opportunity for prevention. The growing number of people with prediabetes worldwide, which directly fuels the epidemic of type 2 diabetes, is now regarded as an imminent public health crisis that must be addressed (The Lancet Diabetes & Endocrinology, 2025a). Early detection and treatment of prediabetes are deemed essential to prevent overburdened and underfunded health systems from being overwhelmed by a sudden surge in type 2 diabetes cases —and to mitigate the economic burden of treating this costly disease and its complications.

Given the various definitions and diagnostic criteria for prediabetes, there is an urgent need for a single, universally accepted, sensitive, and cost-effective blood test to enable widespread adoption of prediabetes screening. Until then, educating people about their risk of type 2 diabetes and prioritising treatment for those at highest risk of progression should be a key objective (The Lancet Diabetes &

Endocrinology, 2025b).

A Practical Case

The above may seem tedious—a mere academic digression with little relevance to everyday life—but this is far from the case. These issues are rapidly transferred to society and, above all, to clinical practice. Below is a copy of an email we received in our inbox in April 2025:

The other day, I went to my mother's nephrology appointment at the General Hospital (she could not attend). My mother is 92 and had been monitored for years due to protein in her urine. Eventually, she stopped going to appointments, but recently the follow-up was resumed.

As soon as I entered the consultation room, the doctor told me her test results were quite good and that they were discharging her from hospital care —the follow-up would now be handled by her primary care doctor according to the discharge report.

I thought that was it, but then suddenly the doctor (very young, by the way -and I get it, we have all been there- typing on the computer nonstop, barely explaining anything, and rather defensive at times —well, honestly, quite unpleasant...) said: "Right, I am going to prescribe her a pill: EDISTRIDE."

I said it seemed like a contradiction, because just moments ago she had told me the test results were quite good (I assumed maybe it had to do with my mother's age or other parameters, but they explain so little). She replied something along the lines of controlling the protein levels in the urine better (or at least that's what I understood, though for years they've been telling us her levels are stable and fine), and also something to do with glucose.

So I asked, "But did not you just say her diabetic level was fine?" And she replied, "Which type of glucose?" I asked her to clarify (by then, both of us were defensive —me, because of her attitude, the lack of information, and the contradictions).

She started using medical jargon: saying that one glucose level was fine, but the other was at, I think, 110. I then asked what would happen if she did not take the pill. And, instead of answering directly, she snapped: "THEN DO NOT TAKE IT!" I then asked -already a bit upset myself- "So what, she is supposed to take it until she dies?" And she replied sharply: "YES!"

Sorry if I am going on too long.

The truth is I left that appointment feeling really uncomfortable. I tried to explain it all to my mother afterwards. I even asked the doctor if I should tell her that her test results were not so

good, and she said, “NO, NO, NO.”

In the lab report, her glucose is listed as 111 mg/dL (normal range 70–110). I’ve read that if glucose levels are between 100-125, it is considered prediabetes, and that to prevent diabetes type 2, they start medicating —basically, treating it as if you already have it. Naturally, this makes you feel afraid. Yes, my mother struggles to walk now and gets little exercise, so I guess the pill seems like the sensible thing —but still, we feel a lot of uncertainty, and even my father and my mother herself are a bit sceptical about it.

I read a 2015 article titled “Diabetes and the Business of Medicalising Health,” in which you are quoted among others: “We are not giving the attention that seriously ill patients need and deserve, while at the same time expanding the range of treatments for those who are not seriously ill. We’re doing it wrong, both at the top and bottom,” Gérvas said. And that is without even getting into the side effects of the drugs (Álvarez, 2015).

Of course, I have read that in order to prevent a small percentage of people from progressing to type 2 diabetes, everyone with those numbers is medicated, and they are treated as though they are already sick. So, like in life, you have to make a choice, and often you just go along with the medication because the doctor says so. But that same doctor does not explain anything, nor does she create an environment where you feel comfortable expressing concerns or doubts. Any time you ask something, the answer comes back defensive, as if you are attacking them.

And... if you decide not to take the medication, you live in fear, because they’ve already made you afraid that something terrible will happen if you don’t.

My mother is already taking lot of medications: ALISKIREN 300 mg, BALZAK 20 mg, ROSUVASTATIN/EZETIMIBE 10 mg, DIGOXIN, ALDOCUMAR... I do not know —maybe I could even send you the lab results with the personal data removed.

Sometimes we really feel lost. The consultation was brief, tense, uncomfortable... you walk out thinking, how am I supposed to ask anything —if they either do not respond, respond rudely, or speak in medical jargon so you cannot even understand.

We have obtained permission to reproduce this email here because it offers a textbook example of what not to do in a medical consultation —both on a human and a scientific level. An elderly, highly medicated woman is prescribed yet another drug, without clear justification for its necessity, and is additionally “labelled” (diagnosed) with a pre-disease: prediabetes. In any case, it clearly illustrates the deep penetration of the pharmaceutical industry into medical practice. In fact, doctors often become,

in effect, “employees” of pharmaceutical companies, receiving substantial sums in the form of so-called “transfers of value.” These payments -officially designated for “education and research”- cover expenses such as travel, reports, attendance at talks and conferences, participation in clinical trials, and the drafting of clinical guidelines. Incidentally, it is worth noting that if such payments were made to other civil servants, they would be considered bribes —criminal offences punishable by law, including prison sentences.

These “transfers of value” are not made at random. They are carefully targeted according to the profit-driven priorities of pharmaceutical shareholders, focusing on specific high-margin products. To promote these, payments are directed to doctors and to “scientific” societies with influence over clinical decision-making. In this way, money -the “purse”- is literally placed above life (Martín, 2023).

Social Prescribing: One Step Further in Prevention and Health Promotion

To the already extensive preventive arsenal of medications (including vaccines for everything and everyone), and to the countless lifestyle recommendations -often burdened with moral and even disciplinary overtones- we must now add the emergence of social prescribing in clinical consultations. Two key terms are used in Spain (Semfyc, 2024):

1. Social Prescribing (SP): SP refers to the process by which healthcare professionals recommend services, resources, or activities available in a person’s community that could benefit their health and wellbeing.
2. Recommendation of Health Assets (RAS): In some Spanish autonomous regions, SP is referred to as recommendation of health assets (RAS). Examples of health assets might include: a community group (for youth, neighbours, the elderly, cultural or sports clubs, etc.), a plaza or park that serves as a meeting place, a civic centre and its activities, and so on. These are resources and activities recognised by the community as health-promoting, capable of improving individuals’ or groups’ circumstances and enhancing both individual and collective skills and capacities.

While these may be framed as “healthy recommendations” or community-based advice, they are still prescriptions —and the word “to prescribe” still means to order or mandate something, especially a remedy. Once again, health professionals, in their role as agents of biopolitics, are given the power to direct and regulate the lives of both the healthy and the sick.

This practice of social prescribing falls more under health promotion than under prevention. Preventive actions aim to avoid specific future health problems. Health promotion, by contrast, seeks to increase overall wellbeing. For example, in the domain of sexual health, recommending condom use during

intercourse is prevention; promoting tolerance toward sexual diversity is health promotion.

As is often the case, the health impact of social prescribing and RAS is modest at best—but what it does reinforce is the medicalisation of everyday life, while opening up new professional niches. One such example is facilitated asset recommendation; a model being implemented in the UK. It involves hiring a link worker or social prescriber who serves as a bridge between health centres and local community resources. The link worker usually operates from the health centre, informing patients about available services. They may also provide support, accompany patients to activities, take a proactive role in organising community events, and help coordinate intersectoral networks (Rodríguez et al., 2023).

Another UK example is as follows: The National Academy for Social Prescribing announced that more than 1,800 general practices had joined the Parkrun Practice initiative, claiming it to be highly effective in promoting preventive care—especially for patients facing barriers to physical activity. Thus, British GPs have started prescribing Parkrun to their patients. Parkrun is a remarkable phenomenon. By 2015, some 50,000 people were already participating in its weekly. Essentially, it is a free, timed, 5-km run, jog, walk, or roll held every Saturday morning in parks, beaches, or trails around the world—but most prominently in the UK, where it originated. It is free, outdoors, community-based, and highly accessible: all excellent things. Parkrun employs a small number of staff, but the set-up, timing, and results processing, are all carried out by local volunteer teams. Today, around 200,000 people participate each week. “Simple, joyful, and cheap”—but must it be prescribed?

To prescribe is to exercise authority and control. It implies the presence of someone entitled to give orders—and others who are expected to follow them. Originally, Parkrun was something to be recommended or shared informally, spread by word of mouth, through personal invitations, and slow organic diffusion. The fact that it depends on volunteers means it belongs to no one and to everyone. Its cheerful atmosphere is always uplifting. Turning Parkrun into a prescription makes it feel less like a pleasure and more like a chore or a mandate. This approach does not foster patient autonomy or the genuine integration of social resources into community health. Instead, it imposes gatekeeping—and quite literally medicalises a walk in the park (McCartney, 2025).

Conclusion

Health is a social product—and it is wise to keep doctors at a distance from both its promotion and the prevention of disease. Deeply unwell is the one who accepts the “tyranny of health” promoted by a Medicine without science, without ethics, and without limits.

Health is the ability to enjoy life. Health is the capacity to face daily problems and difficulties. Health is the ability to enjoy money and love (according to popular wisdom). Health is not the same as

happiness, wellbeing, joy, or mental balance, but it is a source of all of them. Health is a resource for living—not a goal in life. More Medicine does not usually lead to more health. Nor does excessive prevention.

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