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Medicalization: A Complex Social Process

Medicalization has featured as a central theme within the medical sociology literature since the 1970s, but has become contested in more recent years. This contestation has manifested as a key sociological debate concerning the extent to which medicalization should be understood as either a consequence of medical imperialism or as a complex social process involving other social actors. Drawing on the work of Conrad (2005) concerning contemporary drivers of medicalization, the paper argues that limiting our understanding of medicalization to a mere outcome of medical imperialism reduces the utility of the concept of medicalization in the sociological study of health and illness. An analysis of these contemporary drivers guided by both Weberian and Foucauldian inspired theories illuminates the complex social process by which medicalization occurs in contemporary society.

Introduction

Zola (1972, p.498) writes “If done too much or too little, virtually anything can lead to certain medical problems”. This quote sets the scene for understanding medicalization as a sociological concept and the central sociological problem suggested by it. This undergraduate paper endeavours to critically address the debate concerning whether medicalization should be considered an outcome of medical imperialism or conceptualized as a complex social process. By drawing on the seminal works of Irving Zola (1972) and Ivan Illich (1975), and the work of Peter Conrad (1980, 1992, 2005), an overview of both conceptualizations will be provided. The arguments raised throughout the paper will illustrate that theorizing medicalization as a mere outcome of medical imperialism reduces the utility of the concept of medicalization in the sociological study of health and illness. This will be achieved by drawing on Weberian and Foucauldian theories to illuminate the complex social process by which medicalization occurs in contemporary society. The paper will then conclude with a summary of the main points and suggests a more fruitful cross-fertilisation of theoretical perspectives for understanding medicalisation in the 21st century.

Medicalization as medical imperialism

Medicalization can be understood as “a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders” (Conrad 1992, p.209). However, as noted by Conrad, the contested conceptualization of medicalization is evident in the varying definitions of medicalization offered throughout the literature. While Conrad’s definition can be regarded as neutral, others offer definitions that appear to align with a medical imperialist stance, and thus interpret medicalization “as an exaggeration of medical control” (Prosen and Tavčar Krajnc 2013, p.253). One such definition describes medicalization as “a process by which more and more of

everyday life has come under medical dominion, influence and supervision" (Zola 1972, p.235). This definition highlights the dominant role played by the medical profession in the process of medicalization, although it is important to emphasise that Zola sees medical dominion over everyday life and social problems as an outcome of the increasing bureaucratization of modern society and a growing emphasis on treating social problems as technical issues to be solved by experts.

Nonetheless, Zola (1972) emphasises the social control exercised by the medical profession through the process of medicalization, and attributes this largely to its definitional power over health and illness. Similarly, Lupton (1994) argues that medicalization occurs through the successful attempts of the medical profession to convince the lay population of their superiority in terms of medical knowledge and skill. Subsequently, this allows the medical profession to gain social control of the lay population by exerting its authority and dominance in the name of health. As outlined by Turner (1984), while such efforts are made in the name of health, an imperialist stance on medicalization argues that such social control is the outcome of the pursuit of the self-interests of the medical profession.

From a medical imperialist stance, this exertion of dominance has led to medical authorities spreading their influence beyond medical sites alone, thus resulting in the extension of their jurisdiction over issues that previously did not fall within the remit of health (Illich 1975). Indeed, Illich contends that medical professionals exert their dominance in multiple realms of society through the medicalization of what were formally considered social issues. This is particularly evident in an example provided by Pawluch (1983, cited in Conrad 1992) concerning paediatric medicine. During the 1970s, paediatric medicine entered a crisis due to a reduction in the presentation of sick children at paediatric clinics because of improved standards of living and vaccination

developments. To make up for its shrinking market, paediatricians began to medicalize problematic behaviour in children, thus expanding their medical jurisdiction and subsequently developing a new area of expertise - behavioural paediatrics. Similarly, high rates of infant mortality at the beginning of the 19th century lead to the development of Obstetrics and the medicalization of childbirth, which was previously conceptualized as a natural process (Prosen and Tavčar Krajnc 2013). Such examples highlight the manner in which doctors redefine behaviours and everyday life events through a medical gaze (Foucault 1973), thus affording them social control to expand their claim to problems in need of medical intervention.

Such observations are also evident within psychiatry. Jacobson and Kristiansen (2014) emphasise the social basis underlying much of medicine. They argue that medical knowledge is produced in line with dominant social beliefs and therefore reproduce the prevailing social order. Moreover, they argue that psychological symptoms can be understood as violations of social norms dictated by psychiatrists. Goffman (1961, cited in Conrad and Barker 2010) suggests that the construction of symptoms as deviant provide psychiatrists with the control required to medicalize certain behaviours that violate social conventions. However, the level of social control this affords psychiatrists is significantly unjustified given the "weak construct validity" of the diagnostic criteria used to diagnose mental disorders (Pilgrim and Rogers 2005).

The examples provided above concerning behavioural paediatrics, childbirth and mental illness, highlight the active role played by the medical profession in medicalization. Such examples favour the conceptualization of medicalization as an outcome of medical imperialism. This view is further supported by the fact that the medical profession have first claim over what is considered relevant or irrelevant to the jurisdiction of health (Scheff 1964, cited in Conrad 2005). According to a medical imperialist perspective, the jurisdiction of medicine

continuously expands due to the perpetuation of medical dominance. In line with the type of critique offered by Illich, Corteen (2016) argues that this results in the development of a society that loses its ability to cope with natural processes such as aging or with personal troubles and, hence, turns to the quick fix of medical intervention (Corteen 2016).

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However, Zola (1972) contends that this expansion is not the result of medical imperialism; rather, it is the result of the increasingly intricate bureaucratic organisation of society, which ultimately renders the lay population reliant on the expertise of the medical profession. Similar views are expressed by Turner (1984) who examines the contextual factors associated with medicalization. He argues that medicine replaced other institutions of social control such as religion in the process of the secularization of modern societies. Turner (1984) adopts a Weberian view of medicalization (also evident in Zola's theoretical explanation of medicalization) in noting how deviant behaviours once understood in metaphysical or religious terms are increasingly explained in medical terms in line with the rationalization of society. Take the case of infertility: prior to scientific developments in the field of biological reproduction and embryology, infertility was deemed to be caused by the gods but is now understood as a medical issue that can be fixed (Greil 1991, cited in Conrad 1992).

Turner (1984) argues that it is the rationalization of society rather than medical dominance that accounts for the increased medicalization of everyday life. Contra the medical imperialism argument, Conrad and Schneider (1980) highlight the medicalization of conditions in which doctors have had minimal involvement. A host of studies concerning conditions including alcohol abuse (Schneider 1978, cited in Conrad and Schneider 1980) discredit the argument that medicalization is merely an outcome of medical imperialism since it fails to

acknowledge the active role played by lay individuals in the medicalization of alcohol abuse.

This is particularly true of the inclusion of post-traumatic stress disorder (PTSD) in the DSM III.[1] As outlined by Scott (1990), the inclusion of PTSD in the DSM III largely came about due to the political activism of individuals directly or indirectly affected by the Vietnam War. Such political activism arose because of the lack of recognition of the psychological damage of war and the lack of psychiatric and psychological care afforded via medical insurance claims to those affected (Scott 1990). Both examples point to a more complex social process underpinning medicalization than suggested by the medical imperialist argument. More specifically, through the activism of members of the general public rather than medical professionals, a host of what were once considered 'typicalities' associated with particular life events and experiences became medicalised, thus highlighting the complex social process that is medicalization.

Barsky and Boros (1995) suggest that our reliance on the medical profession should be conceptualized in terms of a decreased ability to deal with the trials and tribulations of everyday life leading people to seek specific medical solutions for mild disturbances associated with everyday life. Conrad (2005) illustrates this more clearly with reference to research concerning the extent to which unhappiness has become increasingly medicalized and highlights the frequency with which it is being treated with anti-depressants. Such phenomena are becoming increasingly evident in an Irish context. A recent investigation concerning the prescribing of anti-depressants in Ireland found that prescription rates increased by 28% between 2012 and 2017 (Corrigan 2019).

1 The Diagnostic and Statistical Manual offers standardised classification criteria which is used by psychologists and clinicians in the diagnosis of mental health disorders. The DSM, which is now in its fifth edition, is published by the American Psychiatric Association.

Some authors associate similar international trends with an increasing tendency in self-diagnosing behaviour (Strong, Ross and Sesma-Vazquez 2015). While Zola associates the power of the medical profession with its definitional authority - only doctors have the power to prescribe - yet, its authority and power over the jurisdiction of health is being increasingly eroded by the demands of such consumerist behaviours. As healthcare becomes more commodified, we can expect this trend to continue and intensify.

Conceptualizing medicalization as an outcome of medical imperialism provides only one theoretical lens, namely a social constructivist approach (Bury 1986). While this is useful in highlighting the manner in which medical understandings of conditions come to prevail, it fails to recognize the complexity of the social processes driving medicalization, particularly in relation to political and economic interests. Moreover, it could be argued that the drivers of medicalization have changed to reflect much bigger commercial interests that compete with the interests of medical authorities to protect their professional dominance in the healthcare field (Conrad 2005).

This is particularly relevant in terms of the commercial interests of pharmaceutical companies, which are served by medicalization. Conrad (2005) points to the aggressive advertising strategies used by pharmaceutical companies in the U.S to promote particular drugs and capture new markets. For example, Viagra was initially marketed for the treatment of erectile dysfunction among elderly males or prostate cancer patients. However, pharmaceutical companies later began to target a wider and more lucrative market by claiming that sexual pleasure could be achieved through medical intervention for otherwise healthy men (Carpiano 2001, cited in Conrad 2005).

Furthermore, commercial interests have grown in line with the rationalization of the institution of medicine during the 1980s. Referring to the American healthcare system, Starr (1982) claims that during this time, medical authority

suffered extensive diminishment as the focus of health policy changed from an agenda of equal access to one of economic savings. This led patients to become consumers of health and thus consumerism played a more active role as a driver of medicalization. Exemplary of this shift, is the way in which the body has needlessly become medicalized through an increased consumer demand for cosmetic surgery (Conrad 2005). The extent to which the popularity of aesthetic surgery has risen in line with cultural trends concerning beauty (Mousavi, 2010) highlight the manner in which the implications of shifts in health reforms and the emergence of culturally bound connotations of beauty combine to create a complex social process which results in the medicalization of the human body.

Moreover, consumer demand is increasingly leveraged in expanding the role of biotechnology as an increasingly important driver of medicalisation in the 21st century (Conrad 2005). The role of biotechnology in the expansion of medicalization is particularly relevant with reference to genetics. In terms of the demand for services and treatments, genetics can be understood in terms of its future potential to radically transform medicine in terms of what it may offer the consumer with respect to life enhancement. More specifically, the potential for genetic research to yield interventions to enhance one’s physical stature or mental and social abilities will inevitably result in the expansion of medicalization (Conrad and Potter 2000, as cited in Conrad 2005). More specifically, if genetic research successfully pinpoints the exact genes underlying mannerisms or ways of being such as poor posture or shyness for example, the jurisdiction over what constitutes healthy and unhealthy conditions could be radically transformed. However, for such transformations to occur there would need to be a demand for such services.

One way such demand has already begun to emerge has been through the expansion of medical jurisdiction through the creation of ‘at risk’ populations who can be targeted in terms of their genetic makeup (Lemke 2004). Such

medicalization has occurred through an expansion of genetic testing for rare hereditary diseases such as Huntington's disease to testing for the genetic bases of common, multifactorial diseases (Lemke 2004). Efforts made to identify individuals with specific genetic dispositions related to the development of conditions and disorders have medicalized asymptomatic individuals who could potentially develop such conditions in the future.

The establishment of new technologies of power that combine genetic information with forms of self-regulation is particularly pertinent with respect to genetic medicalization. Both Lemke (2004) and Novas and Rose (2000) draw on Foucault's conceptualization of governmentality to illustrate how these technologies of power link previous family history and future family potentials. Subsequently, a sense of responsibility becomes instilled within the consumer to engage in self-surveillance strategies to reduce or manage the risk of developing particular disorders or passing them on to future generations. O'Brien (2012) suggests that such discourse concerning individual responsibility ties in with neo-liberal imperatives. Shifting the focus away from social risks, which infer responsibility as lying with social institutions, these neo-liberal trends place responsibility on the individual to negate such risk (Lemke 2004). Therein, the neo-liberal trends which emerge from the creation of at-risk populations results in individuals assuming self-responsibility and engaging in self-surveillance to negate such risk, apparently of their own free will.

However, as argued by Novas and Rose (2000), the identification of at-risk populations and the proliferation of risk discourse, which instils a sense of self-responsibility in those who engage with such discourse inevitably serve the economic interests of multiple institutions including governments and pharmaceutical companies. Such theoretical insights further support the argument that medicalization is a complex social process.

Conclusion

While medicalization is best understood as a complex social process rather than merely an outcome of medical imperialism, it cannot be disputed that the medical profession continues to play a significant role in the medicalization of more and more aspects of social life. However, its role should be considered alongside other powerful drivers such as biotechnology, pharmaceutical companies, healthcare policies that encourage the commodification of health and individuals themselves as consumers of health. Those approaches that emphasise the definitional authority of medicine look at the problem through a social constructivist lens. Valuable as this approach is, it can involve blind spots that over-states the problem of medicalization (Bury 1986). In order to provide a more analytical understanding of the complex social process of medicalization, a perspective that examines the role of other drivers or forces (as mentioned above) in addition to taking account of the political and economic conditions underlying healthcare systems operating in specific societies is required (Conrad 2005). In this respect, there is potential for a cross-fertilisation between theories of medicalization and governmentality that also address the play of economic interests and political ideologies.

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