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Beyond medicalisation

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Medicalisation has become a cliché of critical social analysis. It implies something suspect when a problem is created or annexed, in whole or in part, by the apparatus of medicine. Critiques of the ways in which doctors have extended their empire have become part of everyday and professional debate. Such critiques have contributed to the part deprofessionalisation of medicine. Nowadays, the power of doctors is constrained by the shadow of the law, the apparatus of bioethics, evidence-based medicine, and patients' demands for autonomy to be respected, their rights to health satisfied, their injuries compensated. The focus of critique has turned to the methods used by drug companies in search of markets and profits. There is, no doubt, much to criticise. Yet medicalisation has had an even more profound effect on our forms of life: it has made us what we are.

Since at least the 18th century in developed countries, medicine played a constitutive part in "making up people".[1] It was in part through medicine that the human being became a possible object for positive knowledge—a living individual whose body and mind could be understood by scientific reason. Medicine was perhaps the first scientific knowledge to become expertise, in which authority over human beings derived from claims to scientificity. Medicine was entwined with new ways of governing people, individually and collectively, in which medical experts in alliance with political authorities tried to manage ways of living to minimise disease and promote individual and collective health. Medicine was linked to the secularisation of ethical regimes, as individuals came to describe themselves in the languages of health and illness, question themselves against criteria of normality and pathology, take themselves and their mortal existence as circumscribing their values. The history of medicine has thus been bound up with the history of the different ways in which human beings have tried to make ourselves better than we are.[2]

Immediately two cautions must be entered. The we needs unpacking by age, class, race, nationality, sex, and more: some people are more medically made up than others—women more than men, the wealthy differently from the poor, children more than adults, and, of course, differently in different countries and regions of the world. Furthermore, medicine itself needs to be decomposed. The technologies of the operating theatre are not those of general practice, or epidemiology, or public health medicine, or health promotion. Medicine has no essence, be it epistemological (there is no single medical model), political (the power of medicine cannot be reduced to social control or the management of social problems), or patriarchal (medicine and medics do not merely seek control over women and their bodies). Medicine is not a single entity: clinical medicine is only one component among many ways in which individual and group life have been problematised from the point of view of health. And medical knowledge, medical experts, and medical practices play very different parts in different locales and practices. Here I distinguish three dimensions through which medicalisation has made us the kinds of people that we are.

Medical forms of life

The practices of medicine have modified the very life form that is the contemporary human being. Sewage systems, regulated cemeteries, purified water and food, dietary advice, and the general sanitisation of human existence, domestic life, public space, working environments, all in part under the aegis of medical authority, have altered physical appearance—height, weight, posture, capacities—longevity, morbidity, and much more. These practices have changed the relations that human beings have with

their companion species of bacteria, viruses, parasites, scavengers etc. The practice of vaccination—hybridising human beings with dead or deactivated bacteria—has transformed human sociality; saved millions of lives; and contributed to the growth of the population, the possibility of living in towns, and hence urban sociality. The school and the home, transformed by medicine into hygienic machines, have inculcated habits and manners that have become automatic, from table manners to toothbrush drill. Practices for defecation, urination, menstruation etc have produced bodies that are disciplined in relation to health in unprecedented ways. Medical management of sexuality has reshaped regimes of pleasure, practices of intercourse, continence, and incontinence. And so on. We relate to ourselves and others, individually and collectively, through an ethic and in a form of life that is inextricably associated with medicine in all its incarnations. In this sense, medicine has done much more than define, diagnose, and treat disease—it has helped make us the kinds of living creatures that we have become at the start of the 21st century.

Medical meaning

Medicine is inextricably intertwined with the ways in which we experience and give meaning to our world. Whether through medical themes in literature, medical images in art, medical heroes and villains in movies or on TV, medical narratives of patienthood, the imagination of those of us who live in developed countries has become permeated with medicine. This is true for systematic knowledge as much as for popular culture. Many of the theories of society that emerged at the end of the 19th century and through much of the 20th century—from Durkheim to Parsons—understood societies themselves in medical terms, as organic systems whose institutions and processes performed vital functions for the health of the whole. Still today, economies are sick and can be cured, the UK was "the sick man of Europe", racism infects the body politic, etc. The relation between the metaphor and its referent is bidirectional: cancer partakes of the malign character of racism at the same moment that racism is described as cancerous. As lay systems of meaning have become bound up with medical thought, medical languages, no matter how technical, have become infused with cultural meanings. Medicine thus makes us what we are by reshaping the relations of meaning through which we experience our worlds.

Medical expertise

Medicine also makes us what we are through the role of medical expertise in governing the ways we conduct our lives. We might believe that the limits of medicine should be circumscribed by illness, disease, or pathology; that medical authority properly applies where the natural norms of the body have been disturbed by infection, injury, or some other insult; that the proper role of the doctor is to seek to restore that lost normativity of the body. We might think that if medical authority goes beyond these limits it runs the risk of illegitimacy. But this belief would be mistaken. Doctors have long engaged with collective as well as individual bodies. Since the start of the 19th century, perhaps earlier, doctors were involved in the mapping of disease in social space, collection of statistics on the illnesses of the population, design of sewers, town planning, regulation of foodstuffs and cemeteries and much more—indeed doctors have a good claim to be the first social scientists. From at least the mid 19th century, medical concerns embraced not just illness, but health and all that was thought to be conducive to it. And doctors have long been called on to exercise authority beyond therapy; to childbirth, infertility, sexual mores and practices, aspects of criminal behaviour, alcoholism, abnormal behaviour, anxiety, stress, dementia, old age, death, grief, and mourning.[3] Nowadays, there are many examples of such extension of medical expertise to the management of life itself, from new reproductive technologies, through hormone replacement therapy and treatment for age-related sexual dysfunction, to psychopharmaceutical attempts to modify mood, emotion, and volition. The division of the natural and the cultural has ceased to do useful analytical work. Medicine has helped make us thoroughly artificial.

Beyond medicalisation

The theme of medicalisation, implying the extension of medical authority beyond a legitimate boundary, is not much help in understanding how, why, or with what consequences these mutations have occurred. Medicalisation might be a useful neutral term to designate issues that were not at one time but have become part of the province of medicine. It might be a useful slogan for those who wish to dispute the legitimacy of that medical remit. But the term itself should not be taken as a description or an explanation, let alone a critique. Not an explanation for there is no dynamic of medicalisation, no implacable logic of medical entrepreneurship, no single motive of medical interests, that lies behind these various boundary renegotiations; not a description, for there are many important distinctions to be made here. The term medicalisation obscures the differences between placing something under the sign of public health (as in the contemporary concern with childhood obesity), placing something under the authority of doctors to prescribe, even though not treating a disease (as in the dispensing of contraceptive pills to regulate normal fertility) and placing something within the field of molecular psychopharmacology (as in the prescription of drugs to alleviate feelings that would once have been aspects of everyday unhappiness). Nor does medicalisation help as critique, for why should it seem ethically or politically preferably to live one aspect or department of life under one description rather than another? The term medicalisation might be

the starting point of an analysis, a sign of the need for an analysis, but it should not be the conclusion of an analysis.

Assembling forms of life

Medicalisation implies passivity on the part of the medicalised. One example is when people claim that disease-awareness campaigns persuade potential customers to "recode" their unease and dissatisfaction in the form of a diagnostic category to extend the market for pharmaceutical products and the remit of medical practitioners. With notable exceptions (children, prisoners, people deemed mentally ill and admitted to hospital under compulsion), doctors do not force diagnostic labels on resistant individuals. And although drug companies use techniques of modern marketing, they do not seek to dupe an essentially submissive audience. Marketing techniques, since the 1950s, have not regarded the consumer as a passive object to be manipulated by advertisers, but as someone to be known in detail, whose needs are to be charted, for whom consumption was an activity bound into a form of life that must be understood.[4] Marketing does not so much invent false needs, as suggested by cultural critics, but rather seeks to understand the desires of potential consumers, to affiliate those with their products, and to link these with the habits needed to use those products. It is this process of mutual construction, the intertwining of products, expectations, ethics and forms of life, that we observe in the development and spread of psychiatric drugs such as those for depression. This process is not a brute attempt to impose a way of recoding miseries, but the creation of delicate affiliations between subjective hopes and dissatisfactions and the alleged capacities of the drug. Such a medicalisation of sadness can occur only within a political economy of subjectification, a public habitat of images of the good life for identification, a plurality of pedagogies of everyday existence, which display, in meticulous if banal detail, the ways of conducting oneself that make possible a life that is personally pleasurable and socially acceptable. In engaging with these formulae in inventive ways, individuals play their own part in the spread of the diagnosis of depression and shaping new conceptions of the self.

Thus, beyond medicalisation, medicine has shaped our ethical regimes, our relations with ourselves, our judgments of the kinds of people we want to be, and the lives we want to lead. But if medicine has been fully engaged in making us the kinds of people we have become, this is not in itself grounds for critique. Critical evaluation of these heterogeneous developments is essential. But we need more refined conceptual methods and criteria of judgment to assess the costs and benefits of our thoroughly medical form of life—and of those that offer themselves as alternatives.

Conflict of interest statement
I declare that I have no conflict of interest.

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Medicalisation of race

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> "Illnesses that seem identical in terms of symptoms may actually be a group of diseases with distinct genetic pathways. This would help explain blacks' far higher mortality rates for a host of conditions, including diabetes, cancer and stroke."
>
> "Until now, these gaps have been attributed largely to racism in the healthcare sector and widespread poverty among African-Americans."[1]

Biotechnology firms have found an unusual and effective way around the problem of confronting the issue of race as a biological category. The strategy does not deal with the notion in a systematic full-scale case-control design, but uses a clinical study that was not intended to test whether race plays any part–only to discover later that the race of the clinical population, however defined, bears some unknown relation to drug efficacy. The reinterpretation of already obtained data sets by racial categories thereby conveniently circumnavigates the problem of having to define what is meant by race. By sharp contrast, a case-control study that categorised participants according to race would require the researcher to specify the boundaries of the relevant populations. The story of how the first racial drug was approved by the US Food and Drug Administration (FDA) is a remarkable tale of the racialisation of medicine. BiDil (NitroMed, Lexington, MA, USA) is a combination drug (isosorbide dinatrate and hydralazine) designed to restore low or depleted blood nitric oxide concentrations to treat or prevent congestive heart failure. The drug was originally designed without racial specification. But early clinical studies showed no compelling efficacy,[2] and a US Food and Drug Administration advisory panel voted 9 to 3 against approval.[3]