PRESCRIPTIONS FOR LIFE. AN ANALYSIS OF MEDICALIZATION PROCESSES AND SOCIAL CONTROL FROM A COMMUNICATIVE PERSPECTIVE

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Abstract: The present paper aims to analyse the medicalization processes in its role as a high-profile theme of the contemporary society, as it is being linked to developments in various fields such as science (biomedicine, cloning, genetically modified organisms), technology (new genetic biotechnologies, nanotechnologies) and communication. We are interested in identifying the social mechanisms that lead people to give a medical approach to those aspects of their lives that normally are unrelated to medical phenomena, and therefore studying, from a communicative perspective, the interactions between actors involved in the medicalization of life. We explore the topic using the SWOT analysis as a tool to (a) identify weak and strong points of such processes, and (b) evaluate the threats and opportunities incurred. The analysis reveals that medicalization can lead to undesired stratifications within a society, marginalization, and "patologization of existence". On a positive note, it can enhance the patient – doctor relation when the communication processes between the actors involved (medical care institutions, pharmaceutical industry, mass-media, administrative and political authorities, and surveillance organizations) are improved.

Keywords: communication, medicalization, risks, benefits, social control.

Introduction

Imagine this: you, sitting in a very comfortable armchair, listening to an audio-book, with an inspiring e-cigarette at hand, sipping from a cup of Ginkgo biloba tea... Now imagine this: you, sitting in a very comfortable armchair (because your physio-kineto-therapist told you to do so and only so to keep under control your scoliosis), listening to an audio-book (because you are afraid that, at your forties, too much reading might deteriorate your sight), with an inspiring e-cigarette at hand (both because you are desperately trying to give up smoking and because you naively still believe that smoking will inspire you to write something down for your future novel), sipping from a cup of Ginkgo biloba tea, that plant believed to have amazing effects on your memory and concentration capacity that they promote on TV and that your GP confirmed to be having nootropic properties, and recommended it to you, "just in case". This is far from a futuristic scenario and may be fictional only on paper, but not as disturbing as the reality it hints at: the medicalization processes and their impact on health issues, illness management, and the construction of social life in the current society.

Theoretical background

One of the most popular definitions for the concept of medicalization belongs to Peter Conrad, who described it in his article "The Discovery of Hyperkinesis: Notes on the Medicalization of Deviant Behaviour" as a process of "defining behaviour as a medical problem

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or illness and mandating or licensing the medical profession to provide some form of treatment for it" (Conrad, 1975: 12). We have to pay particular attention to the idea that when talking of the medicalization of life we refer to variety of phenomena once belonging to fields like education, religion, human anatomy, or economy (fields generally unrelated to Medicine and medical approach) that have been redefined and treated like medical phenomena. In fact, we are talking about a change in the perception of both professionals and lay people regarding aspects of everyday life, by making them part of the medical care process: menopause, pain, unemployment, sadness and other non-pathological moods are just some examples of medicalization processes that could lead us, as Spanish journalist Pérez Oliva points out, to develop hypochondriac attitudes (Pérez Oliva, 2009: 7-8). But after all, how did we get here?

One important aspect of medicalization is its connection to the progresses registered in the (post)-modern society: progress of science (biomedicine, cloning, genetically modified organisms, etc.), progress of technology (new genetic biotechnologies, nanotechnologies, etc.), and progress of communication (a globalized interconnected world, from which notions like centre and periphery have disappeared or have been stripped of their common meaning, others, like proximity, have changed their meaning; wireless and satellite communication, sophisticated mobile technologies, iPads, etc.). It is in this new socio-cultural (but moreover economic and political) environment, where the post-modern citizen was brought up. He was designed as a well-informed individual, up-to-date with all the new technologies available out there, very concerned with and really determined to invest in his well-being. Thus, this new citizen has engaged himself in a quest for self-comfort, aiming at living as long as possible, in the best shape and with the best help, as he is aware of the technology advances available and all the progress registered in genetics field and others. He is the medicalized individual, obsessed with the chimera of a perfect health. "The irony of this development is that the goal of a perfectly healthy population – bodies that are 'natural' and unmedicalized – can only be achieved by the individual internalization of a totally medicalized view of life" (Nye, 2003: 119). We are assisting today to a "patologization of the existence", as Gori and Volgo describe the process of social life medicalization (Johanne Collin and Jacob Suissa, 2007: 26). But this individual prototype could not have gone this far without the tacit or explicit participation of other actors equally or even more responsible for what medicalization means today. Consequently, we believe that a brief introduction of these actors is necessary, since our intention here is to apply a SWOT analysis on how the doctor – patient relationship has evolved towards medicalization, due to visible or less visible negotiations between the actors involved in such processes: scientific community, pharmaceutical industry, mass-media (PR, advertising and journalism), physicians community, governance and non-governmental institutions (surveillance communities). Normally, the most frequent and visible encounters are those between patients and doctors, so they represent the two main sources for medicalization. As Soledad Márquez and Ricard Meneu stressed out, "the physicians are the main medicalization agents. (...) Without their participation, the other actors of medicalization will not be able to get the desired demands for their offers" (Soledad Márquez and Ricard Meneu, 2007: 73). Further on, a negotiation machine is set up: physicians can engage in collaborations with both researchers and pharmaceutical industry, depending on the interests involved. For example, the rationale behind the construction of some new drugs could be explained by the links that individual researchers or investigation groups establish with representatives of the pharmaceutical industry. Of course, in this negotiation process, media, as one of the most efficient tools for the public understanding of science, cannot be left aside. But sometimes, advertising jumps in, and the media promote specific drugs or cover more extensively

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certain "scientific discoveries", or even use directly the voices of doctors who are in positions of leadership to deliver targeted messages to specific social groups. As a result of advertising campaigns, and with involvement from medical staff, lay people could easily fall into medicalization routines not even being aware of it.

Since lay people cannot get into direct contact with the scientific community, there is always a mediator in need, and usually this role is played by media organizations, although the governance (local or central authorities, public administration) could also play an important part. Mistrust in political authorities has determined people to put their hopes and believes into what their physician will tell them in terms of what is good or bad, what is recommended or not. Still, many of the decisions and choices people make are strongly based on self-assessments of what they see, hear, like, dislike, believe, accept, reject, etc. The main point here is that, basically, the processes of medicalization (treating as medical condition aspects of life never before part of the medical intervention) are justified by the evaluations or interpretations people make in terms of the risks and benefits they see in the observed reality. From this perspective, different forms of medicalization have appeared as a consequence of the recent growth in number of physicians or persons with medical competences, observed changes in the demographic structure of the society (especially the processes of ageing), the multiplication of therapeutic practices (focused on prevention) to the detriment of pathologic practices (based on treatment), and also the extension of medical competences into fields unrelated with medicine and healthcare issues: school failure, sexuality, marital problems, psychiatric expertise, birth and death, menopause, etc. (Poulain, 2002: 192-193).

Using the risks and benefits model that lay people appeal to in order to assess what affects their lives, we will approach the four dimensions of the SWOT analysis starting with what normally is related to the beneficial part – Strengths and Opportunities [Medicalization+], continuing with the "risky side of the business" that is Weaknesses and Threats [Medicalization–], and ending with some final considerations in an attempt of an overall diagnosis.

Medicalization+

This scenario does not offer many chances of success in finding strong points for medicalization, and actually there is a general concern regarding the medicalization of so many aspects of the individual's life (see Nye 2002, Pavone 2007). Nevertheless, despite this general negative perspective, some positive aspects could be highlighted. In assessing medicalization, one of the strongest points and actions to recommend it refers to the shift of paradigm in the medical intervention from treatment to prevention. In other words, preventing is easier and cheaper than treating. From this perspective, on the long run, putting an emphasis on prevention can imply that hospitals will "host" only those who really need to be there. So, from a pragmatic point of view, medicalization can have a positive effect on decentralizing the medical unities, in the sense that the patient himself can manage those treatments not requiring permanent medical assistance from home. Obviously, the risk is huge: by encouraging prevention, cases of de-medicalization or over-medicalization – that is to self-interpret and diagnose, due to the "empowerment" that prevention gives to the patient – can occur (Márquez and Meneu, 2007: 69), and what it was meant as a good initiative ends up as being another weak point for the medical system.

As it has been stated, for people in the contemporary society, health is an essential subject. Individuals have a high level of awareness regarding the importance of health in a society, partially due to the fact that they took control over their own well-being, instead of

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letting others be in charge of this. Starting from this point, the great opportunity that could be exploited is raising awareness in those countries or places where medicalization has not arrived yet. But it is difficult to use as an opportunity something that, cynically, is considered a commodity in the modern societies and a basic necessity in some developing countries and in the majority of those underdeveloped. When the weaknesses and threats of medicalization are discussed, we will insist more on how medicalization and bio-medicalization can reinforce social stratification and generate discrimination. Moreover, another positive aspect of medicalization refers to the very dynamic relations it generated between the actors involved in the process, even creating particular publics that felt their voice should be heard. In his article on biotechnologies and social change, Vicenzo Pavone reviews the actors that play significant roles in the decisional arena of new biotechnologies: "besides politicians, scientific community and industry, the new biotechnologies also include in the list of stakeholders actors that never had leading roles in other sectors of public policies management" (Pavone, 2007: 16), and he names patients' associations (involved in funds raising, by lobbying), or consumers' associations (very active in the area of GMOs) among others. His stance is on a public participation as wide as possible as a viable model of governance of science and technology. And, after all, public debates, as long as they exist, lead to the general perception that the decision is a product of negotiations between all the involved parts, and not a discretionary measure of those privileged.

Medicalization–

The debate on the positive or negative implications of medicalization and its impact on health, social life, social control and identity, changes depending much on the analysis frame invoked. For instance, from a religious point of view, the medicalization of life raises many questions as it aims at manipulating the biblical truths, promising a prolonged life to those who embrace these processes. Economically speaking, medicalization represents an opportunity for some markets or professions, like the pharmaceutical industry or the physicians' community: medicalization generates more and more patients in need of pills, attention, and, when advertising is involved, lies.

From other perspectives, like the sociological or the philosophical one, the vibe is more positive. For example, as sociologists put it, the problem of medicalization lies in the understanding of the mechanisms that make possible a shift from non-medical to medical; in consequence, interest should move towards the identification of the processes that legitimate the inclusion of social phenomena in the medical sphere. Most commonly, the legitimacy of contemporary medicine is due to the recent scientific and technological successes, "translated" by the media or other interested instances, in terms of progress in lifespan growth. Of course, if for scientists this means a step forward in human evolution, more moralistic or philosophic approaches are not so optimistic: overpopulating the planet is not such a success, since it is already overpopulated. Not only is the control of death open to scrutiny, but also the control of birth: the possibility of genetically designing a child raises many, many questions and puts science into difficulty. According to Vicenzo Pavone, the scientific community lacks awareness: it is not aware that "the new technologies have not only an ethical and cultural impact, but also social and political consequences that the science itself is not capable to understand and manage" (Pavone, 2007: 11).

Medicalization is the reflection of these transformations in modern societies. "We witness different types of legitimacy transfer: from religious to medical, from moral to medical, from magic practice to medical, from family to medical institutions. The almost systematic drive for

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the media to turn to medical experts to comment on certain aspects of the everyday life is a signs of the new social functions that medical staff took over from priests and other conscious guides", concludes Jean Pierre Poulain in his book *Manger aujourd'hui. Attitudes, normes et pratiques* [translation into English: *Eating today. Attitudes, norms and practices*]. The consequence of this synthetic conclusion is that this pervasiveness of medicalization was, is, and will be expected to bring about meticulous analysis from part of the society itself, from traditional practitioners in the fields it intruded on, from patients, etc. Until now, these constant actions of scrutinizing have brought to light weaknesses of medicalization, but also aspects that make it a threat to others and even to the process itself.

The legitimization of medical competence in fields traditionally unrelated to Medicine has led consumers to have very high demands from physicians and, in general, from the hospital as an institution, also due to rapid innovations in technology, progresses of biotechnology and health related issues. Besides being a weak point itself (there should always be some more time left between when a new discovery is made and the moment it is communicated to lay people), this issue of high expectancies generates another one: a severe deterioration of the patient – doctor relationship, including sometimes a confusion of the roles played. Journalist Pérez Oliva explains how we got here: "The way of communicating all this progress – often in an epic and hagiographic language, for a society each day more hedonistic – has made the population, and especially the new generations, have excessive expectations in contrast with the possibilities that Medicine now has." But, she continues, "With its way of acting, medicine had its own contribution to these false and excessive expectancies from the public, putting in difficulty the doctor – patient relation, a more and more problematic matter because of this new patient profile, who is more cultivated, well informed and more demanding. Many doctors have noticed how some of their patients arrive at the physician with unrealistic requests and demand things that a doctor finds impossible to guarantee" (Pérez Oliva, 2009: 7). One of the threats deriving from this new mentality is the possibility that the number of malpractice accusations (from part of the patients) really might grow, generating mistrust in medical expertise. Hypothetically, we can wonder if not part of the malpractice accusations (popularized by the mass-media) also are rooted in the medicalization practices that some patients embraced at some point of their existence.

Summing up the negative parts of medicalization exposed so far, we have to remember its implications in the deterioration of the patient – doctor relationship and the mistrust of the patient in the success or proper execution of medical intervention. These weaknesses can lead to another interpretation in terms of threats: many of the medicalization processes related to the patient – doctor relationship have been misunderstood by both sides: the doctor lost control over medical diagnosis, and the lay public/ patient has, thus, gained too much power so that he can decide what a disease is and what it is not. Discussing this risk of not knowing how to distinguish a disease from non-disease or false disease, Márquez and Meneu refer to "inadequate elaboration of suffer" (Márquez and Meneu, 2007: 69-70), explaining the medicalization of some aspects of our existence that normally are not and should not be under medical care or supervision.

There is a growing tendency towards the medicalization of almost everything, from unemployment to beauty, infancy or education, to give some examples. Events from individual reality are conspicuously approached with fear. One of the threats concerning the medicalization processes is related to what we earlier in this paper referred to as "patologization of the existance" (see *supra*): in the current consumerist culture, people tend to develop obsessions related to prevention care and health. Replicating somehow the story of the hunted hunter,

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journalist Pérez Oliva concludes: "We consume health the same way we do with any other product and, finally, we will end up like consumed consumers." (Pérez Oliva 2009: 20).

We have already discussed the interactions between the different actors of medicalization and the dynamics it generates as positive, and therefore, a strength. Nevertheless, it also has a negative side because it can lead to polarizations and stratifications within a society. As explained, medicalization is linked to the access that people have to information and, thus, to knowledge: not being aware of what is going on can leave one outside the "game". In other words, not everybody can benefit from the medicalization processes! Those who does not have the power (from a symbolic point of view) to generate public debate, to set agendas, or to set trends will remain outside the decision-making area. Consequently, they will not contribute to the social definition of food, health, illness, nutrition, doctor-patient relation and other associated issues: "discursive models can exclude marginalized communities and sectors of society that often do not have a visible voice or representation in political debates" (Blue: 149-150). Although affecting everyone, only some get (to be) involved, due to unequal opportunities in life. Talking about marginalization in a broader sense, journalist Pérez Oliva links it to new technologies and progress, interdependently related: "New Technologies have the power to interconnect every spot on the planet, but this process, like it happens all the time with all processes, is not homogenous. With a world organized in a web, not being part of it condemns you to profound social exclusion, for it implies not having access to knowledge" (Pérez Oliva, 2009: 2).

Another type of marginalization includes those who cannot afford medicalization not as whim (as it happens with the most cases), but as a need. From this perspective, medicalization is cynical and defying, serving economic interests (which also lead lay people to mistrust the scientific communities, for the too frequent partnerships with politicians or industry), and not "the community". Obviously, it is not an obligation to do it, but it could be an extra "+ point" and a way to avoid the danger of what is called *healthism* (term probably coined by the political economist Robert Crawford in 1980) described by scholars as a phenomenon with great potential to distort public health priorities, to increase health anxiety, through media hype and risk inflation, with huge economic implications of escalating demands for tests and referrals, and its threat to the morale and well-being of health professionals and to clinical and public health research. On a more positive note, others have written on the potential for strategically harnessing the energy of health-aware consumers to build positive clinician–patient relationships and to drive system-wide quality improvement initiatives in healthcare (Greenhalgh and Wessely, 2004: 199-200).

Conclusions

We cite here the opinion of a physician, Gilbert Welch, who said for the *LA Times*, that "there are many areas in which medical care has a great deal to offer. But it has now gone well beyond them. There may have been a time when the words 'Do everything possible' were indeed the right approach to medical care. But today, with so many more possibilities for intervention, that's a strategy that is increasingly incompatible with a good life. We all need to be a little more sceptical and – to really be healthy – willing to ask 'Why?'"

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