

Medicalization Reconsidered

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Frank Furedi argues that the “old” ways of looking at medicalization are, well, old. Medicalization and professionalization are no longer linked in a frenzied dance of mutual replication. Today, the “top-down” medicalization of a bygone era of “medical imperialism” has been replaced by a “bottom-up” medicalization reflecting the rise of the “expert patient,” the influence of advocacy and self help groups, and the transformation of lay experience into a “privileged status.” For Furedi, “the main driver” in this metamorphosis is the “transformation of the docile patient into a consumer or an active patient in search of a diagnosis.” With “routine problems of existence” ever more likely to be viewed through “the vocabulary of medicine” and interpreted as “illness categories,” and as physicians become occupationally marginalized within the health care workforce, Furedi adroitly concludes we must look elsewhere for answers to the undeniable and unchecked expansion of the medical gaze.

I found Professor Furedi’s arguments on how the currents of professionalism could *no longer* explain the rise of medicalization intriguing. I wanted to learn more, if only to balance some of my own thinking about professionalism in a historical context. What I uncovered in this search was a pivotal date, two missing witnesses, a mysterious alias, and one confounding attribution.

A Confounding Attribution

I want to begin with what appears to be a troubling inconsistency between Furedi’s professionalism of old and what I encountered in my selective readings of the medicalization literature. As noted above, one of Furedi’s core arguments is how “the intentional promotion of professional power” and “the promotion of narrow professional interest” can no longer be considered as the main driving force of medicalization. Moreover, I learned a principal thinker in the medicalization literature (Peter Conrad) *now believes* (emphasis mine) that doctors “play a more modest role in the promotion of medicalization even as they still serve as gatekeepers

for medical treatment.” The message I took away from this was that Conrad once believed otherwise at some point in his work on professionalism.

My problem, in a nutshell, is that I failed to find Furedi’s Conrad. I also failed to locate arguments substantively identifying organized medicine’s purposeful promotion of, and striving for, professional power as *the* (or at least main) driving force behind medicalization (possibly due to my too-narrow reading of the medicalization literature). The closest Conrad comes to such a position is in his inaugural (1974) medicalization article on hyperkinesis, where he highlights “expert control” and “medical social control” as key problem areas. Even here, Conrad notes that “outside (medical) agents” also are “significant in ‘promoting’ hyperkinesis as a disorder within the medical framework.” Similar positions and statements can be found in his follow-up book with Joseph W. Schneider (*Deviance and Medicalization*, 1980), and across his medicalization work as a whole.

For example, in his 1992 review article for the *Annual Review of Sociology*, Conrad notes that medicalization is a “sociocultural process that may or may not involve the medical profession, lead to medical social control or medical treatment, or be the result of intentional expansion by the medical professional” (p. 211). Similar assertions can be found in his 2004 *Journal of Health and Social Behavior (JHSB)* article with Valerie Leiter, and his most recent 2005 *JHSB* overview where he summarizes prior studies and identifies (with examples) three “prime movers toward medicalization,” only one of which is the “power and authority” of the medical profession (the other two being “interprofessional or organizational contests,” and “social movements and interest groups”).

In sum, Conrad’s publishing record, which includes periodic summaries of the general medicalization literature, does not identify the forces of professionalization as a principal driver of medicalization. As for Conrad believing that today’s physicians occupy a more subor-

dinate role than previously and that the medicalization of today is dominated more by commercial interests and market (rather than professional claims-makers)—he is guilty as charged. However, neither of these two positions addresses, front and center, the issue of whether medicalization, in the past, was primarily dominated by the “promotion of narrow professional interests.”

A Pivotal Date

One matter that resonated clearly with both Conrad and Furedi was the identification of the 1980s as a key decade in the accelerated processes of medicalization. Clarke and colleagues (2003), arguing a thesis of biomedicalization in the *American Sociological Review*, offer an even more targeted date (“about 1985”). What then is there about the 1980s that proved to be significant in the evolution of medicalization as a social force? Conrad, Furedi, and Clarke all provide explanations, and while the collective list is quite plausible and valid, there is one rather dramatic transformation that occurred early in the 1980s that does not appear—that being the 1982 shift in an economy gripped by an almost decade-long economic recession (1973-1982) to what would become this nation’s longest running (August 1982-1997) bull (stock) market.

Of course, none of this happened in a socioeconomic and political vacuum. A number of other social and technological factors helped to birth and, subsequently, nourish this “bull.” Two examples, of many, are the exponential leaps in information technology and, second, the failure of the Clinton Health Plan. The latter sent a clear message to the capital marketplace that there would be no politically imposed solution to health care reform—at least at the present time. The former allowed both investors and emergent health care managers to manipulate, often for the first time, large amounts of data (such as physician payment records).

First Missing Witness: The Capital Market

Like the dog that failed to bark in Sir Arthur Conan Doyle’s 1937 short story, *Silver Blaze*, I concluded my readings of Furedi and of Conrad and others, with the unshakable feeling that there were elements missing from the medicalization picture. Over time, I centered my attention around two such “missing witnesses,” the capital marketplace and science. In the case of science, I was intrigued with the possibility of treating medicine and science as distinctive social forces. What if, over time, medicalization has become less

about medicine and now more about science? As for capital, I wanted to break through some of the terms (e.g., medical marketplace) used in the literature as proxies for “competition,” “industry” or some other aspect of economics.

Instead, I wanted to focus more directly on the role of capital as a determining factor in the possibly distinctive trajectories of medicalization and professionalism. It was not so much that “the market” was missing from the medicalization literature. Conrad and Leiter even highlight the term in their 2004 article title (“Medicalization, Markets and Consumers”). Furedi also uses the term. However, I did not want to talk about competition or about “market oriented... attacks on medical autonomy.” Even Conrad and Leiter’s distinction between “medicated” and “private” medical markets was not quite what I had in mind. I wanted to focus on money (lots of money) and as I read the medicalization literature, I thought the capital marketplace was an under-appreciated venue in what we might call a “future’s-market” in health care innovation and change. I believe that things like physician shortage (or surplus), medical research, electronic medical records (EMRs), Medicare fraud, and health care quality play an important role in understanding health care change. Nonetheless, debt and equity are only part of what is bought and sold on Wall Street. Wall Street also invests in potentials—be that the potential for a new technology to transform the earnings of a particular company or market sector, or the potential of a new form of organization (e.g., managed care) to do the same.

The fact that Wall Street invests in bricks and mortar, as well as dreams, allows Wall Street to have a secondary or second order impact on the transformation of health care. Crassly put, while medical managers, policy analysts, and academics during the 1990s wrestled on the factory floor to make managed care work, analysts, money managers, and capital investors were making their own assessments as to the benefits of reorganizing health care in this manner and, in turn, were placing their own bets on managed care as a transformative tool. None of this is to claim that good ideas shorn of money are worthless, or that throwing enough money at a problem will solve all ills. Nonetheless, the fact remains that the withdrawal of money from a company or project (with investors cashing out) does little to enhance its future success. As health care shifted from the 1970s to the 1980s, organizational in-

novations like managed care became an object not only of academic/political/and managerial attention but of capital as well. This shift had a tremendous impact on all aspects of medicine, including medicalization and professionalization.

One additional point can serve to anchor the above points. In the 1970s and early 1980s, "health care" (and for the remainder of this section, "health care" means "health care as an object of capital") was a relatively undifferentiated entity. Basically, there were two types of health care companies (actually, even the term "health care companies" did not exist in the 1970s) for investors to consider: pharmaceuticals and medical equipment.

All this changed during the 1980s and 1990s. The key was internal differentiation. "Health care" went from a few dozen companies to hundreds—and then thousands. Investors (such as pension funds) poured billions of dollars into nascent health care companies and dreams. Some of these companies prospered (Columbia/HCA [now HCA] went from two hospitals in El Paso, Texas, to the nation's 49th most valuable company in little over ten years). Other companies crashed and burned (drkoop.com, named after the former Surgeon General C. Everett Koop being one such example).

This emerging differentiation was more than just the raw number and types of companies. As the number of companies grew, so did the "type" of investment vehicles offered to capital by Wall Street. Within a decade, health care went from "big pharma" and medical equipment to literally hundreds of different health care investment vehicles. Investors could buy the stock or debt of thousands of individual companies, but they could also buy mutual funds and/or "indexes" that focused exclusively on health care stocks. Mutual fund giant Fidelity Investments, for example, has five major types of health care portfolios: (1) health care, (2) biotechnology, (3) medical delivery, (4) medical equipment and systems, and (5) pharmaceuticals. Other mutual fund families, in turn, have their own portfolios and their own ways of aggregating—and thus defining (and this is a key point)—"health care."

MSN.com's Money Central (URL: www.moneycentral.msn.com) groups health care stocks into nine different sectors: (1) medical instruments and supplies, (2) medical appliances and equipment, (3) health care plans, (4) Long-Term Care Facilities, (5) Hospitals, (6)

Medical Laboratories and Research, (7) Home Health Care, (8) Medical Practitioners, and (9) Specialized Health Services. Moreover, these nine sectors do not include "Drugs"—which has its own list of seven subcategories from "Drug Manufacturers—Major" to "Diagnostic Substances."

In an extraordinarily short period of time, the relatively small and undifferentiated market of "health care" became an intense object of capital, and in doing so became highly diversified and ever more heterogeneous. Of course, none of this could have happened without a number of other social and technological factors falling into place (e.g., information technology and the failed Clinton health plan mentioned above). Nonetheless, one of the major shifting forces in the 1980s was the discovery of health care and medicine by investors, who found a number of new places to make and lose capital. American medicine was profoundly changed by this discovery, all of which brings me to my second "missing witness."

Second Missing Witness: Science

"Science and technology" underwent its own transformation (including internal differentiation) on Wall Street during the 1980s. Our major focus here, however, is not capital (although this most certainly is part of the picture—and for the same reasons outlined above), but rather the relationship of science to medicine. Historically, the work of science and medicine has been so intertwined as to appear inseparable. Much of medicine's historic power and privilege as a profession was tied to this apparent "oneness"—and to the public's belief that the practice of medicine was fundamentally science-based. Over time, however, appreciable holes began to surface in this picture. John Wennberg, for example, repeatedly documented how the local customs and habits of physicians better predicted their practice patterns than the scientific literature. In turn, this new literature could be laid alongside the traditional literature that documents the lag between the introduction of scientific discoveries and their adoption by physician-clinicians.

Throughout the 1990s and into the twenty-first century, doing "scientific work" (such as in the wet lab environment of the basic scientist) became increasingly differentiated from doing the work of clinical medicine. Newspapers hired "science" writers and even theoretical physicists (e.g., Stephen Hawking) became household names. The rarified world of the M.D./Ph.D. physician-scientist became differentiated as some of these "dual

citizens” began to reverse their title (symbolically) and identify themselves more with the scientific research than with the responsibilities of patient care. Supporting this shift (but probably more like “fueling it”) are the job descriptions, percent time FTE (full-time equivalent) allocations, and formal conditions for salary and raises that underscore their work identity.

I wonder if science (or scientific evidence) is beginning to have a distinctive role in the medicalization process, and therefore should be viewed so in an analytically distinct way. For example, what would push chronic fatigue syndrome (CFS) and/or fibromyalgia to be labeled a disease rather than a “condition”? And does science have anything to say about this? The contested status of CFS and fibromyalgia as a disease versus a condition has generated considerable sociological and medical attention. In fact, the medical literature often reflects this identity-tension by taking particular care in how it labels these entities—using phrases like “controversial illness” and “disorder.” Nonetheless, both CFS and fibromyalgia have distinctive clinical-medical identities. Both also have well-established diagnostic criteria, the former via the Centers for Disease Control and the latter from the American College of Rheumatology. Finally, both have ICD-9 (International Classification of Diseases) codes (780.71 and 729 for CFS and fibromyalgia, respectively). Yet both continue to exist, both within and outside of medicine, as “suspect diseases.”

Organized medicine presents us with an ambiguous set of answers to the question of whether CFS and fibromyalgia are bona fide diseases. How then are we to move beyond this impasse? One possible answer is—science. There is a basic science literature for both CFS and fibromyalgia, a literature that is reasonably distinct (citation counts would be one criteria) from those of sociology and medicine. At the present time, this literature is dominated—and defined—by gnostic research. One consequence of this research was on display recently when the international news media headlines reported; “Chronic fatigue is linked to immune system,” and “Genetic basis found for chronic fatigue syndrome.” Another reported: “But now, scientists have found evidence that the condition which has been widely disparaged as “yuppie flu,” is biologically based and quite real.” All of a sudden the medicaliza-

tion discussion for CFS appeared to shift and, if only for a moment, CFS became more disease-like. Even the business media (and therefore Wall Street) tracked the story.

This same science also resides (but more indirectly) behind Furedi’s discussion of deskilling and how other types of health care providers come to perform the diagnostic and treatment work once reserved for physicians. When people go to these once-upon-a-time-medical-underlings, why do they believe what they are told? After all, clinical diagnostics and disease attribution are

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not games of chance. There are very real, and sometimes false positive and false negative diagnoses can have fatal outcomes. The fact that we find (in this discussion and in Furedi’s) the term “diagnosis” being used (instead of “personal opinion” or “guesswork”) is telling in that it accords these “alternative providers” a certain measure of legitimacy and respect. Why are we so inclined? Could it be that patients now have more faith in

the underlying science than in the provider?

To compound matters even further, we also have become a society of experts. We have experts/consultants for a seemingly endless list of everyday life events—including the makeover of closets and my personal favorite, the “lifestyle consultant.” Given the timing, I cannot help but wonder if the rise of “lifestyle medicine” and the impact of “controllable lifestyle” on resident specialty choice share an underlying social antecedent with the rise of the lifestyle consultant?

A Mysterious Alias

There is a second and more shadowy figure in the medicalization debate. It operates under the nom de plume “disease mongering.” The two most recent sightings (April 2006 for both) are the “First Inaugural Disease Mongering Conference” held in Newcastle, Australia (see <http://www.diseasemongering.org>) and the concurrent publication of a thematic issue in *PLOS* (Public Library of Science) *Medicine*. The two literatures (on medicalization, and disease mongering) are not particularly inclined to acknowledge each other. For example, the 2005 *JHSB* review article by Conrad never mentions the term “disease mongering,” while the largely UK-based medical mongering literature is only slightly more likely to make reference to its

medicalization brethren. It would appear that both literatures have little in common—except for their topic of interest. But the two appear quite similar. The *PLOS Medicine* thematic issue editors Moynihan and Henry define disease mongering as “the selling of sickness that widens the boundaries of illness and grows the markets for those who sell and deliver treatments,” and as “*campaigns that inappropriately (italics mine) widen the boundaries of treatable illness*” (<http://medicine.plosjournals.org/perlserv/?request=index-html&issn=1549-1676>). Conrad, in turn, defines medicalization in his 2005 review article as “*The essence of medicalization became the definitional issue: defining a problem in medical terms, usually as an illness or disorder, or using a medical intervention to treat it*” (italics Conrad). There are, of course, possible differences. One might be a epistemologically focused medicalizing versus a commercial and profit cued mongering.

The Infection of Self-Identity

Like deprofessionalization, Furedi’s treatment of self-identity and medicalization is clear, concise, and cogent. With the growth in medicalization comes a disturbing trend for people to define themselves by their disease. Although Furedi does not employ concepts such as “principal” or “master identity,” his examples of those who “claim to positively value being deaf or blind” leave little to the imagination. Individuals who link identity and illness come off as wantonly manipulative, somewhat silly, or as members of some marauding identity-seeking gang that will stop at little to have their self-images medically validated and/or legislatively endorsed. It is within these contexts that Furedi also mentions chronic fatigue syndrome and fibromyalgia.

As a sociologist, and as a person with several (different) disabilities, I find Furedi’s linking of identity and disease to be personally distressing and conceptually disconcerting. We live in a country (USA) that today is riddled with chronic disease, a country whose adults are appreciably sicker than their British counterparts (“Study Says Older Americans Are Less Healthy Than British”—*New York Times*, May 2, 2006), and a country where cancer is now considered a “chronic condition” (because of improvements in diagnosis and treatment). The United States also is a country where millions endure needless assaults on their corporal and mental well-being not because they embrace illness as

an identity, but because they either refuse, or are unable (because they are not properly diagnosed) to do so. Rather than attempt to argue what is admittedly a complicated issue, I will resign myself to a brief example—diabetes.

As a chronic medical condition, diabetes has yet to be singled by the heat of any medicalization debate. Individuals with diabetes, particularly Type One, will die if not diagnosed and treated. In turn, the administration of too much or too little insulin (the principal treatment), can itself quickly induce coma and death. The best prognosis is associated with a “tight control” of blood sugars, attained by an extremely aggressive—some would say “Spartan”—program of lifestyle and dietary changes, and an almost religious attention to monitoring one’s blood sugars. The longest survivors of Type One diabetes are two brothers, Gerald and Robert Cleveland, age ninety and eighty-six, respectively, whose attention to diet and lifestyle is understatedly characterized by one physician-researcher as “a little bit obsessive about their records and their diets” (*New York Times*, February 5, 2006). In short, the problem here, as is the case with many chronic diseases, is not an *over-identification* with disease, but rather a societal-wide *unwillingness* to associate one’s self with one’s underlying pathology. In short, the problem is *under-identification* not *over-identification*. With exquisite irony, we are bombarded with widely published and easily accessed morbidity and mortality statistics, yet we expect the downsides of our denial to befall “the other guy.”

There is a similar configuring for other medical conditions. My own severe loss of hearing is my most socially disruptive/damaging disability. Although I consider myself as someone “with a disability” and not a “disabled person” (I do find the latter label, when used by “hearers,” to be dismissive and personally offensive), I still see my hearing loss as a core part of who I am, and what I am, 24/7. I cannot stop being “deaf,” nor can I afford to forget the socially damaging fact that if someone says something to me and I do not respond (because I did not hear them speak), that the social consequences can be severe—for me. While I do not let this omnipresent threat dictate my social life to the point where I refuse to engage in anything but one-on-one, face-to-face conversations, the possibility that I might respond to a social greeting as a non-event causes me to keep my social radar constantly attuned. This is physi-

cally draining and socially consuming. Nonetheless, it is the price I pay. I gain absolutely nothing by claiming that any hurt feelings are the fault of an insensitive public or a society that “does not understand.” Like the Cleveland brothers, I ignore my bodily limitations to my own peril. In one of life’s consummate ironies, I do not know when I “don’t hear,” and therefore I am unable (on my own) to remediate damaged social situations. The best I can do is to try to prevent others from labeling me as a socially imperfect or invalid person (even as they do so for the wrong reasons—“Fred the snob” versus “Fred the deaf guy”).

The “medicalization of self-identity” is a vastly more complicated issue than represented in Furedi’s article. The problems (from a personal and societal health perspective) of over-identification pale beside the extraordinary indifference maintained by under-identification.

A narrative links our pivotal date, two witnesses, a mysterious alias, and what we now might term the “alleged medicalizationists.” In my search for the latter, I kept bumping into a particular date—the 1980s—and it was the proverbial, “I wonder what else is going on here?” that brought me first to Wall Street and then to the second missing witness in this tale—science.

This picture linking medicine, science, and Wall Street will become even more complicated and contested in the future. Clarke and colleague’s biomedicalization thesis is telling in this regard. If you “live” and work in an academic medical center, as do Clarke (University of California, San Francisco) and myself (University of Minnesota), it is flat-out impossible to ignore the whirlwind of tensions as the modern medical school lurches among its own holy trinity of education, research, and clinical medicine. What used to be canonical (education) has become marginalized as the quest for research dollars and fame, patents and licensing agreements, and the pressures to generate ever more clinical service revenue, have displaced education as core to the medical school mission.

Today, literally dozens of schools brazenly announce their intention to become “top twenty NIH (National Institutes of Health) funded” institutions—seemingly oblivious to the fact that most will fail, if not based on the sheer number of those seeking this status, then on the fact that the current “top twenty” have no intention of giving up their coveted spots. It is also telling that the push to generate increased clinical and research

revenues is taking place within a playing field where medical schools must compete with for-profit corporate research and health care companies—the large majority of which are public entities (stock issuing), and therefore companies where investors (e.g., owners) will help to decide—via their investment dollars—whether something like (for-profit) contract research organizations rather than university laboratories are the wave of the research future.

The world is an evermore flat and transparent place in which the miracles and messes of our social institutions become fodder for news media, Internet chat rooms, bulletin boards, and blogs. Like medicine, science will continue to endure its own public trials about its trustworthiness and essential commitment to the public welfare. Science, like medicine, has its own social contract with society, and it is because of this contract that public reckonings distinguish between the powers of science *applied to medicine* and the powers of science *as medicine*. All of this bodes well for social scientists—particularly those who seek to understand the ever-fluid and complex discourses that move across medicine, science, and society.

FURTHER READINGS

- Conrad, P. 2005. “The Shifting Engines of Medicalization.” *Journal of Health and Social Behavior* 46: 3-14.
- Conrad, P., and V. Leiter. 2004. “Medicalization, Markets and Consumers.” *Journal of Health and Social Behavior* 45 (Suppl): 158-176.
- Moynihan, R., I. Health, and D. Henry. 2002. “Selling Sickness: The Pharmaceutical Industry and Disease Mongering.” *British Medical Journal* 324: 886-891.
- Moynihan, R., and D. Henry. 2006. “The Fight against Disease Mongering: Generating Knowledge for Action.” *PLOS Medicine* <http://medicine.plosjournals.org/perlserv/?request=index-html&issn=1549-1676>.
- Parker-Pope, T. 2006. “Trials and Error: In Study of Women’s Health, Design Flaws Raise Questions: Scientists Fault Conclusions on Fat, Calcium, Hormones as Often Unduly Negative: NIH Defends the Research.” *Wall Street Journal*, February 28, A1, A13.

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