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BOOK REVIEW

Peter Conrad, The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders

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Although the Oxford English Dictionary does not give Peter Conrad the credit for inventing the term ‘medicalization’—their first reported usage is in the New England Journal of Medicine in 1970—it has been indelibly associated with him since the publication of his doctoral research on hyperactive children in the mid-1970s. Over the succeeding years, however, the concept has taken on a life of its own as other writers have appropriated the idea and applied it to a wide range of problems and domains. In the process, it has lost a great deal of the precision that Conrad sought to achieve. The Medicalization of Society reviews the evolution of the term and seeks both to clarify its refinement and to note the ways in which its referent has changed over the last 30 years.

As Conrad himself acknowledges, the basic idea is not new. It is a strong theme in Michel Foucault’s work: indeed the translator of Birth of the Clinic uses the word in 1966, 4 years before the OED’s first recognition of its existence. We might even cast back to the German poet JW Goethe, writing in 1787: “Speaking for myself, I too believe that humanity will win in the long run; I am only afraid that at the same time the world will have turned into one huge hospital where everyone is everybody else’s humane nurse.” Goethe’s quote captures the essential ambivalence of medicalization. On the one hand, it promotes a humane society, where deviants are treated with kindness and sympathy and reformed rather than punished, as Parsons saw in his brilliant analysis of the parallel roles of medicine and law in social control. On the other hand, it can also lead to a world where there are no real troubles or conflicts, merely individual problems in adjustment that can be corrected with the appropriate chemical or behavioral interventions.

In its recent history, Conrad notes, medicalization emerged in the 1970s from the medical imperialism thesis of the 1960s and shared many of the same assumptions. Previously excluded or marginalized social groups challenged the assumed beneficence of the medical profession and the health care system. Doctors, in particular, were characterized as agents of a social order stratified by gender, race and economic self-interest, seeking to extend their jurisdiction in support of mass oppression. To borrow from C Wright Mills, medicine was a key agent in turning public issues into private troubles: women’s depression, for example, was not a rational response to injustice but a clinical problem to be solved with the correct medication. In the process of expansion, doctors acquired wealth, power and privilege as control agents and, like, any other capitalist entrepreneur, found themselves driven to create new markets as old advantages were competed away and profits fell. Childhood hyperactivity—what would now be called ADHD—was one example, where the behavioral problems of US children, faced with an uninspiring educational system and a domestic environment threatened by the stresses of mass labor and mass consumption, could be resolved by medication. The doctors who led this diagnostic innovation and expansion created a new source of profit and a new area of professional control.

Even at the time, this analysis was questioned empirically. It was never clear to what extent it held in countries

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where health care was more actively managed by the state, whether through taxation or social insurance: hyperactivity never took off on a large scale in the UK or Europe, for example. As Phil Strong pointed out, in a study of UK primary care physicians and their alcoholic patients, front-line doctors in a capitation-funded system had few incentives to medicalize new problems. It was important not to confuse the highly visible activities of the profession's moral entrepreneurs with coal-face practice. As Conrad notes, other studies also showed the degree to which medicalization might be a preferred strategy for patients, and generate social movements in support of this goal. Medicalization allowed people with stigmatized problems to gain access to the privileges of the sick role, although it has also raised important questions about the implications of the formation of solidary communities of the sick, something which troubled Parsons greatly for its potential in overloading the carrying capacity of even an affluent society. Conrad also observes that the rise of complementary or alternative practitioners did not necessarily affect the underlying dynamic of expanded control: dependence was dependence, whether it was on medication prescribed by a licensed physician or a herbal product recommended by a traditional healer. In some respects, CAM filled the gaps where allopathic medicine hesitated to meet demands from potential patients to cede responsibility for their problems. Although 'right-on' medical sociologists might find themselves co-opted to the jurisdictional projects of CAM practitioners, the medicalization thesis suggests that we should apply the same critical scrutiny to any form of healing imperialism.

The biggest gap, however, was, as Conrad points out, a serious analysis of corporate players. During the 1970s and 1980s, medicalization focused on doctors and patients. If doctors were agents of white, patriarchal capitalism, the routes by which this was accomplished were left unspecified and unexamined. In particular, pharmaceutical companies simply made drugs available: physicians took these up and created the markets for them. Since the 1990s, however, the drivers for medicalization have been more clearly identified with the pharmaceutical industry. In part, this reflects the shift towards managed care and the growing constraints on diagnostic entrepreneurs in convincing third-party payers to fund new conditions and associated treatments. Indeed, this often became an issue for patient social movements: Conrad discusses the example of transsexuals pressing to retain a psychiatric diagnosis for their condition, so that they could still get funding for gender reassignment surgery, in contrast to homosexuals, who sought, successfully, to have their orientation removed from the DSM list of recognized disorders. A potent cocktail of falling returns from the squeeze on pharmaceutical budgets by managed care providers, the increasing costs of bringing innovative products to market and the growing difficulty of discovering new therapeutic entities shifted the drivers towards the pharmaceutical industry. A key moment in this process was the FDA Modernization Act of 1997, which permitted direct-to-consumer (DTC) advertising of prescription medicines. The alien nature of the USA comes through strongly for us Europeans when we turn on the television to be confronted by a barrage of drug advertisements. Clearly, there is a somewhat unholy mutual dependence between the pharmaceutical industry and the mass broadcast media in the USA. Although sociologists have paid some attention to the content of the advertisements, their material base seems to have attracted less scholarly interest, although Big Pharma must surely rank with Big Tobacco as a social, cultural and economic interest worthy of scrutiny.

The new frontier, though, according to Conrad, is the human enhancement industry. Here the potential is unlimited, in the sense that it is largely financed by private consumption rather than by managed care. Cosmetic surgery and genetic testing are the goldmines of the early twenty-first century. Medicine moves on from the definition of behavioral problems as fit objects for its attention to the creation of new physical problems. In the UK, our celebrity magazines trace the breast surgery careers of models and actresses, for example, where the DD implants of one phase are replaced by C sizes as the fashion changes. Looking further ahead, we can see the potential for cognitive enhancements, achieved through medications rather than psychological interventions. In the process, our cultures produce ever narrower definitions of acceptable body morphisms and mental engagements, definitions that can rarely be sustained without extensive and profitable interventions. Paradoxically, physicians may become our allies in resistance to these processes. If they do not, what is left of their professionalism beyond a very basic level of consumer protection?

While Conrad's book is comprehensive, thoughtful and reflective in its account of a major contemporary theme in medical sociology, and will serve well on any course that examines this topic, there are, perhaps three areas where it might have been a little more adventurous—and which may need more attention as the years go by.

One is its ethnocentrism. This is a harsh criticism given Conrad's genuine efforts to reflect the contributions of European writers. Sometimes he does not get us quite right: the NHS does not, as he correctly says, cover the cost of Viagra except where certain specified disease states are present, but physicians are not allowed to charge an extra fee for a prescription. He does not, too, always use his obvious knowledge of European health care to probe the extent to which the contours of medicalization in the USA reflect a unique constellation of national incentives rather than generic features of health systems in developed

countries. What I particularly have in mind, though, is the situation of allopathic medicine and its associated corporate interests in countries that have genuinely plural healing systems. Conrad rightly remarks that we cannot assume that traditional healers do not engage in medicalization. However, we do need to give further attention to the extent to which 'medicalization' adequately captures the current experience of countries like India and China, where allopathic medicine has not had the socially, legally and politically entrenched market dominance that it has in the USA and other developed societies.

A second point, and this is not a criticism of Conrad so much as of medical sociology in general, is a failure to look outside the silo. The same society that has been witnessing a radical expansion of the jurisdiction of its health system has also been seeing a radical expansion of its legal system. Medical imperialism has been paralleled by legal colonialism. Indeed, at various points, the two enterprises have come into competition and conflict. Sociologists of law have been no better than medical sociologists at acknowledging the co-existence of these twin processes. However, I would suggest that it makes a considerable difference to the analysis of each to consider its place alongside the other. The extended 'soft policing' of the USA by its physicians is coincident with the expanded 'hard policing' of its law enforcement system. The USA may be a highly medicalized society but it also imprisons and executes a greater proportion of its citizens than almost any other country. As Parsons showed us, medicine and law are complementary systems of social control: the simultaneous expansion of both surely says something about the nature of governance in general that has yet to be captured by the specific sociological studies of either.

Finally, and related to both of the above, I am not sure that we really understand enough about the drive to marketization in health care and the withdrawal of states to minimal roles in consumer protection rather than active regulation. How far is medicalization a substitute for state action rather than an alternative or a challenge? I have recently been involved in some work on the future organization of the profession of pharmacy in the UK. Licensing is being removed from the professional association and taken over by a state-controlled board, as with all other UK health professions. Within the English vision of the NHS, the strategy seems to be to impose a minimum standard on actors who will then be left to compete for patients and state-funded services in a more or less unregulated market. This also reflects the growing intervention into the field of health care, in both England and at the level of the EU, of government departments and agencies concerned to promote competition and markets for professional services, at the expense of those concerned with health. The case for permitting DTC advertising, for example, is being pressed in the name of competition and open markets over the objections of health interests concerned to manage demand. The English health department is increasingly decoupled from any ability to manage the market in pursuit of public health objectives, although the Scottish Government is still pursuing central planning and collaboration with its professionals around a strong public health agenda. English patients are consumers, while Scottish patients are citizens of a communitarian welfare state. If the state sees its role in health care as essentially residual, providing a minimal set of entitlements with minimal regulation and relying on competition for patients/consumers to distribute resources and manage the system, then medicalization is likely to expand as providers compete for business. This applies both to professionals and to corporate interests seeking both to enlarge the market by introducing new diagnoses or enhancements and to enlarge their own share at the expense of other actors.

None of these comments should detract from the intrinsic merits of Conrad's book. It is an invaluable synopsis of 30 years' scholarship that will save many of us a great deal of burrowing through books and articles. It is clearly written and presented so that it should be accessible to students in both sociology and health studies. Peter Conrad has made an immense contribution to medical sociology and it is a pleasure to be reminded of this.

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