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Medicalization as a Critique of Modernity

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Abstract

Representatives of the medicalization thesis in sociology propose that in modernity the human condition is increasingly translated into quantified and medical terms. Problems are increasingly reduced to issues of individual and public health. On the one hand, this results in an increase of government intervention in the lives of citizens, concentrating power in the hands of experts, while politics legitimates itself via medical expertise. On the other hand, subjects themselves demand medicalization as a form of recognition. Medicalization as a sociological paradigm problematizes the modern drive to construct issues in medical terms. However there are no easy answers, as alternative medicine too is a form of medicalization. More reflexivity is warranted when it comes to problematization and categorization of phenomena associated with the human condition.

Keywords

medicalization, modernity, human condition

Introduction

According to sociologist Peter Conrad, "medicalization" broadly refers to the social process by which the human condition as such in modern societies has gradually come to be defined as a specifically therapeutic or medical issue (Conrad, 2007). It should be emphasized from the outset that medicalization is typically identified as a social construct, that is, this phrase refers to epistemological categorizations perceived as being end products of certain institutional frameworks. This by no means implies any ontological denial of the phenomenon's existence in itself. Adherents of the medicalization hypothesis also do not deny the subjective experience of persons who perceive themselves as being ill or in need of treatment. Medicalization is not therefore a completely relativist knowledge claim regarding the existence or non-existence of phenomena outside mechanisms of categorization. What this approach *does* highlight, however, is the crucial role cognitive framing processes play when it comes to how modern society handles issues related to the human condition. The human body has always been prone to diseases and syndromes. Medicalization, on the other hand, means more than questioning the historicity of the epistemological criteria used in the diagnosis of diseases: the critical edge of this approach is manifested in the way it thematizes medicalization as *over-medicalization*. Although certain examples can be mentioned (homosexuality, masturbation) that have gone through successful demedicalizations, exiting the scope of pathologization and medical care, overall the range of human phenomena subject to medicalization has been expanding rather than contracting (Conrad, 2013).[1] Medicalization can be used productively to reflexively critique modern power/knowledge structures.

Methods

In this research, we conducted a literature review of the medicalization literature, referencing both the general framework, as elaborated by Professor Peter Conrad and his students, as well as specific examples to elucidate how medicalization can and has been used to analyze specific cases. What we are interested in is the way in which modern societies categorize problems and dysfunctions of the human condition in specifically scientific and medical ways. Of special interest for us is how many social institutions have an interest in medicalization. This research trend can be used effectively for conceptualizing power in the 21st century, as well as problematizing what the human condition means.

Results

Through an analysis of this corpus of sociological literature, we can find see how both medicalization and demedicalization operate in the context of modernity. While there are no easy answers as to precisely which phenomena ought to be medicalized in the first place (problematic examples abound), an awareness of the mechanisms of medicalization and demedicalization can help make decision-making and activism more cogent and reflexive, providing various political actors with conceptual tools needed to account for the shifting processes of knowledge and

1 Even in the case of „successful" demedicalizations, the potential for remedicalization is always prevalent. The issue of male circumcisition is a case in point, which was progressively repathologized from the HIV/AIDS pandemic onwards (Carpenter, 2010). According to some, the ongoing search for a genetic basis for homosexual orientations could potentially contribute to the remedicalization of homosexuality (Conrad & Angell, 2004). That being said, pessimistic forecasts for the remedicalization of homosexuality as a consequence of HIV/AIDS never came to fruition (See: Dennis, 1997). What these examples show is that demedicalization too is not a one way-street and is not resistant to remedicalization.

power. In our view, medicalization as a social science paradigm can have diverse applications, especially in relation to future pandemic situations. The COVID-19 global pandemic seems to fit into a longer term tendency, which can be characterized as the medicalization of biopower. This can prove fruitful in later research, when it comes to decribing the complex relationship between political and scientific forms of power. Of special importance is the delocalization of medicalization: as distinct from the 1970s, today alongside the state, other actors too, even individual subjects themselves, have a vested interest in continued medicalization of human problems.

Discussion

The Medicalization of Life

Potentially, even human characteristics and behaviors considered completely normal until now can become pathologized, such as aging or death.[2] According to Jennifer Harding, by the 1990s, medicalization had already reached such an extent that it was impossible to isolate non-medicalized elements from the medicalized ones (Harding, 1997). Even if it does not promise complete elimination of undesirable factors, mainstream Western medicine does acknowledge and promote the postponement of fate as an explicitly or implicitly affirmed normative basic value. Moreover, the imperative to increase the secularized and quantified "life expectancy" of the general population is for the most part not even questioned or reflected upon by even practitioners of so-called "alternative" medical techniques. More often than not, medical professionals of all stripes generally accept that medicine ought to have a key, even central role, in the regulation of human life. When, instead of searching for the ultimate truths, we are curious about how to actually live our individual or collective lives, what rules to follow, what is correct human behavior, what is the secret of a good life, then nowadays we turn to representatives of the medical sciences or lifestyle consultants for help, expecting useful answers from these fields. A philosopher or sociologist cannot compete with a physician. The COVID-19 pandemic has made it abundantly clear that increasingly no social sector can rival medicine in terms of credibility, legitimacy and public trust. This expansion of medical powers carries enormous risks, noted by a large segment of the sociology profession. In this article, we shall deal with two interrelated strands of inquiry. On the one hand, we hope to show how medicalization can be critiqued, while also accounting for the way Western subjectivity is constituted by medically informed biopolitics. On the other hand, our aim is also to how how Michel Foucault's work intersects with the key concerns of medicalization scholars, and in what ways the insights elaborated by this research can be deepened via a productive hybridization with Foucault's biopolitics framework. The COVID-19 crisis underlines the dependence of modern subjectivity upon a medicalizing biopolitics for its legitimacy. Medicalization research helps us realize that the social control phenomena associated with the pandemic are radical manifestations of pre-existing biopolitical power structures.

From Medical Imperialism to Self-Medicalizing Docile Populations

The first serious social scientific criticisms of the perceived supremacy or hegemony of medicine in Western secularized societies were formulated during the 1970s. This was a period when numerous social movements, such as the anti-psychiatry movement, questioned the

2 Adherents of transhumanism, for example, look forward to a techo-optimistic cornucopian future where death has been defeated by the advance of medical technologies. The idea of human immortality brings with it important biomedical questions that lie outside the scope of this essay.

knowledge monopolies of experts. Critical theories that emerged in this era were primarily conceived in a libertarian or even anarchist spirit, drawing attention to the simultaneous expansion of the powers of the state and institutionalized medicine. Indeed, these early writings primarily conceived of medicine as being a social control mechanism, an instrument of power wielded against non-conformist minorities or individuals labelled „deviant" (Zola, 1972; Conrad, 1975). Anarchist theorist Ivan Illich wrote of „medical imperalism," a supposed tendency on the part of the medical profession to increase its power at the expense of society as a whole, playing into the technocratic desire for control on the part of the state (Illich, 1976). In these early discourses, medicalization appears as the imperialism of the medical profession, as well as a power control mechanism imposed on society from without, by expert classes in collaboration with ever more powerful governments. In this respect, Thomas Szasz can be highlighted as a prime example of early critics of medicalization, who developed a systematic critique of the so-called "therapeutic state" and its institutions (Szasz, 1977). However, it soon became clear that focusing on the therapeutic state alone is not enough. Medicalization is about more than just a political struggle over the precise boundaries of medicine, although this too is an important component of the broader theme of medicalization. Technocracy can function in the smoothest possible manner if the population voluntarily demands endless treatment, and subjects consider their own lives as worthy of being prolonged in time, motivated by a secularized fear of death. The population itself demands, and even actively participates in, the medical categorization and management of human phenomena and problems.[3] Medical power is more than a mere tool in the hands of an authoritarian state. At the risk of stating the obvious, when we speak of medicalization, we are talking about more than the mere self-interest of the medical profession: we are dealing here with a comprehensive, internalized *episteme*, on a civilizational scale.

If we suffer from an illness, condition or syndrome, we understandably wish for relief, and in late modernity, medicine can be considered the function system of society that, due to various reasons, shoulders the primary responsiblity for reducing suffering. We do not wish to dispute the legitimacy of medical science or the validity of the desire to reduce human suffering to an acceptable level. But it is all too simple to forget that all care is palliative, to a greater or lesser extent. What counts as an optimal human lifespan, for instance, is open to debate.[4] According to proponents of the medicalization thesis, the integration of the human condition into medicine has become all-encompassing in scale. According to David Armstrong, medicalized modernity can be summarized as „a world in which everything is normal and at the same time precariously abnormal" (Armstrong, 1995). Suspicions of over-medicalization are most likely to arise where categorizations become unforeseeably broad and unstable, while changing over a very short period of time. We may cite the classic example of ADHD (attention deficit disorder) in the 1980s. A single definitional change in the DSM–III manual, the gold standard for the diagnosis of psychological ailments, permitted 50% of children to be categorized as potentially suffering from "attention deficit disorder" (ADHD), exponentially increasing numbers eligible for medication (Conrad, 2007). Did the

3 Such examples from the relevant literature include the institutional acceptance and medicalization of PTSD by war veterans' advocacy movements, AIDS by gay rights movements, and PMS by women's rights movements (Scott, 1990; Kayal, 1993; Rittenhouse, 1991). In large part, government funding for issues is more forthcoming if these are framed in explicitly medical terms. A more recent example is the framing of „systemic racism" in the United States as a „public health" issue (Mendez et. al., 2021). An intriguing possibility is the potential medicalization of racism, which brings with it a host of issues, such as the potential for blamelessness being imputed to ill persions „diagnosed" as being „racist." For a forceful critique of the medicalization and individualization of racism see: (Wellman, 2000).

4 Indeed, the very category of „optimality" is a social construct. On the frontiers of anti-aging medicine for instance, proponents of amelioration clash with adherents of optimization (Mykytyn, 2008).

number of children suffering from ADHD really increase many times over in 1987? The probability of this is quite low indeed.

In addition to the therapeutic state, there are many other drivers of medicalization in late modernity. For example, drug manufacturers are among the main financiers of advocacy organizations dealing with adult ADHD (Conrad, 2005). This raises questions regarding the displacement and multiplication of the focalization points of medicalization. No longer are we confronted by a centralized power structure. The expansive tendency of medicalization has certainly not abated, but according to Conrad, we may discern many centers working towards the same goal, and compared to the 1970s, it can be interpreted as a being much less state-centered process. Medicalizing tendencies certainly are attributable to the bureaucratized, centralizing therapeutic state. The process is not solely driven by the representatives of medical science, although the latter are also primary "gatekeepers" of relevant medical knowledge. But role of the private sector has increased in its scope, especially as a result of deregulations in the 1980s and 1990s. Pharmaceutical manufacturers and health insurers also have a vested interest in translating all human problems into medical terms. The expansion of health insurance to cover ever wider areas does not bode well for proponents of demedicalization.[5] Humanitarianism and the profit motive are inseparable.

Women's reproductive health has been an area of interest for the pharmaceutical industry for a very long time. Nowadays female contraceptive medicine is in the crosshairs of certain tendencies within the feminist movement that thematize the objectification and medicalization of female bodies (Grigg-Spall, 2013). Medicalization, of course, is not restricted to women or other subaltern groups. As a result of the authorization of Viagra in 1998, the aging male body also became the subject of pathologization. Demand for the medicalization of the human phenomenon extends to all genders. With the arrival of sexual performance enhancing drugs, the terrible truth was revealed: half of late 20th century North American men were exposed as sexually "suboptimal," so they needed a potency increase (Conrad, 2007). While sexual "potency disorder" can be assumed to be a biogenic and not psychological problem, Viagra as a "self-affirming destigmatizer" helps to reveal underlying problems evaluated as existing, opening the ground for gender self-optimization and supposedly positive self-constructions (Conrad, 2007). The subject, at least in a Western cultural context, seeks to optimize itself. Destigmatization of existing suboptimality goes hand in hand with market expansion, and in this way everyone wins. Before we interpret this example solely as constituting an example of market hypertrophy, it is worth paying attention to the emerging pattern: the prerequisite of medicalization is the destigmatization and pathologizing of conditions previously accepted as fateful, and a subsequent communicative reframing of formerly providential circusmtances as being changeable, treatable and open to amelioration.

In late modernity, government becomes, to quote Michael Oakeshott, "an association of human beings undergoing treatment" (Oakeshott, 1975). Politics, social policy in particular, are increasingly reduced to a permanent therapy of the populace. Of course, the ambition of life regulation is much broader than the extent of the therapeutic and/or welfare state alone, although due to the centralized health insurance structures, the state, especially in the context of Western Europe, is never far from the center of the biomedical complex. After all, a key question in the case of all medicines is to what extent should they be covered by health insurance, who should pay how much and why. Such economic considerations, while ostensibly related to decentralized institutional systems such as the market, are actually

5 Without wishing to dispute or, worse, downplay the validity of the subjective experiences of those suffering from depression, a most serious illness, similar suspicions - individualization, depoliticization of social dysfunctions, excessive pharmacentrism – can nonetheless be raised in relation to the treatment of depression via biochemical means (Bröer & Besseling, 2017; Conrad & Slodden, 2013; Mulder, 2008).

indicative of a "teleocratic drift" or path dependence. By "teleocratic drift" we understand the increasing subordination of society to the fulfillment of specific goals. According to Oakeshott, while liberal societies leave it to the individual to pursue individual goals and do not prescribe common goals, illiberal societies develop common plans, which force the population to act collectively in order to fulfill them. The danger of this lies in the fact that priorities may become uncertain, i.e. if society focuses its resources on the current agenda, other areas may be neglected. Teleocracy thus leads to an overall less complex social structure than more decentralized, pluralistic social alternatives. (Oakeshott, 1975). For example, the population as a whole may be compelled by governmental violence to concentrate its attention exclusively on public health and public hygiene, to the detriment of other considerations. Such a concentration of societal attention, while occasionally undoubtedly necessary in the case of public health emergencies, brings with it enormous social costs in the form of structural imbalances, blind spots and double binds.

Health, and public health in particular, has become a meta-value of sorts, accepted by practically all social actors, enjoying an almost universal legitimacy. From this monotony even alternative or "holistic" remedies do not offer any refuge. We can talk, for example, about "deprofessionalization without demedicalization" in connection with "holistic" or "traditional" healing methods informed by New Age and similar spiritual/alternative medical trends (Conrad, 2007). There is no aspect of subjectivity that cannot be pathologized, and the mobilization of alternative healing techniques is not in itself sufficient to demedicalize a certain human phenomenon. The distinction between normal and pathological[6] can be applied to any phenomenon, provided that the appropriate diagnostic categories exist. It should be emphasized that when we talk about "medicalization," we do not necessarily mean "overdiagnosing." The first is a qualitative concept intended to both critique and describe the process whereby even the most basic human phenomena *can*, but not necessarily *do*, become categorized as pathologies amenable to therapy. On the other hand, "overdiagnosing" is a quantitative concept referring primarily to debates surrounding the identification of concrete phenomena within the scope of already medicalized areas of human life (Hofman, 2016). Medicalization as a sociological paradigm problematizes the way modern society translates all undesirable phenomena, sensations, and conditions into medical terms.

Conclusion

In late modernity, knowledge is increasingly open to contestation. Alongside positivist and scientistic forms of knowledge, alternative medicine has appeared, leading some medicalization theorists to propose „medical pluralism" as a description of the present situation (Correia, 2017). Instead of countervailing or balancing medicalization, alternative medical knowledges have resulted in a further expansion and complexification of the medicalizing tendency outlined above. What this indicates is that there are no easy answers when it comes to medicalization. Modern subjects demand solutions to problems of the human condition — the best we can do is increase awareness of the manifold power relations associated with knowledge.

6 The first serious philosophical examination of this binary was carried out by philosopher of science Georges Canguilhem, who was incidentally (also) Michel Foucault's doctoral supervisor (see Canguilhem, 1966/1978).

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