

# Medicalisation: the definition of disease and the role of tomorrow's doctors

## DISCUSSION

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### ABSTRACT

Medicalisation transforms formerly non-medical aspects of human life, bringing them under what Foucault called 'the medical gaze'. Physicians, the definers of disease and gatekeepers of diagnosis, have traditionally held the sole power to medicalise. However, as the patient-doctor dynamic and medical training continues to shift away from a paternalistic model towards holism, and we enter an era where personalised medicine is becoming more prominent, medicalisation is increasingly driven by external forces. These forces range from pharmaceutical companies to socio-political movements to patients themselves. Medical students and physicians have a responsibility to understand these forces and how they influence the practise and scope of medicine.

Medicalisation is “a process by which some non-medical aspects of human life become to be considered as medical problems”. (1) As future diagnosticians and definers of disease, medical students will play a part in medicalisation; however, the ‘engines’ of medicalisation are increasingly shifting to external forces which medical students and practitioners have a responsibility to understand. (2) This paper examines how medicalisation is occurring within various social, political and environmental spheres, and how medical students inherit responsibility for the complex problems that subsequently arise.

### **The sociological constructs of health, illness and disease labelling**

To understand medicalisation, it is essential to recognise the ambiguity in the definition of disease. Objective criteria or results plotted on a normal distribution are often the clinical standard for health or disease; however, this approach may be reductionist, losing the impact and nuance of disease in the patient’s context. The World Health Organisation (WHO) takes a more holistic view, defining health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. (3) However, this definition may medicalise areas of human experience which are non-pathological variations – for example, the ‘non-diseases’ described by the BMJ, which include socially important issues such as ageing. (4) For example, although it is normal to experience a decline in physical ability with age, (5) the WHO definition suggests that most or all elderly people are unhealthy, a blanket description of a heterogeneous group. There is in fact marked variation in health status in older people (6) and self-rated well-being is among the highest of any age group in the UK. (7)

### **Healthcare medicalisation**

Diagnosis and disease labelling is an essential part of medicalisation. As medical practitioners, we should be aware that labelling a patient with a disease is not a trivial or benign act. It impacts the human experience – it may be cathartic, or it may lead to anxiety and stigma, requiring considerable work to pass as ‘normal’. (8)

For example, a patient in his seventies presents to the memory clinic. His wife has noticed a progressive decline in his memory and cognitive ability. His father had a long and difficult battle with Alzheimer’s disease. He insists that he receive no diagnosis and the symptoms be attributed to old age. This is a difficult scenario as diagnosis and treatment of these symptoms may help to slow the disease progression, but the distress of anticipating what happened to his father means that a lack of diagnosis outweighs the benefit of receiving one.

It may be difficult to avoid medicalisation through disease over-labelling. The following case demonstrates how the desire of medical practitioners to diagnose and classify may mean that avoiding one form of medicalisation leads to another.

A young man presents to a genito-urinary medicine (GUM) clinic with pearly penile papules who insists on their surgical excision. The doctor explains that this is a normal variant and suspects that surgery will not address the patient’s underlying dissatisfaction with his body image. The doctor considers his psychological needs and whether he could have body dysmorphic disorder (BMD). However, it is important to establish the degree of interference with daily life in order to distinguish BMD

from non-pathological body dissatisfaction, otherwise the practitioner may be substituting one medicalised diagnosis for another. (9) Inappropriate diagnosis would lead to the harms of stigma and over-treatment.

There is also the potential for iatrogenic harm in medicalisation through over-diagnosis and over-treatment. Once the diagnostic label is received, the patient enters the medical world and is then potentially subject to unnecessary invasive and harmful tests and treatments. This is particularly important in screening programmes – over-diagnosis occurs when screening identifies an illness which would not have caused problems during the patient's lifetime. For example, screening for abdominal aortic aneurysms to pre-empt rupture will identify some cases which would, in fact, have remained asymptomatic. Selection of appropriate patients to intervene with is therefore important – if the deaths from preventative surgery outweigh the deaths due to the condition going unnoticed, harm has been done. (10)

Finally, increased diagnosis might not benefit anyone – identification of papillary thyroid cancer has increased threefold in 30 years, yet the death rate has remained stable, suggesting 'zealous imaging' has merely identified many low-risk tumours. (11)

### **Political and social medicalisation**

A recent emerging trend has centred around medicalising issues formerly considered to be socio-political problems, influencing how they are dealt with and their impact on human experience. For example, the Weight Management Centre reports a trend in depoliticising obesity by medicalising it into a diagnosis. (12) This shift invokes Parsons's 'sick role', (12) absolving the patient of responsibility for their obesity and placing the onus of recovery on medical treatment with the compliance of the patient. This classification of disease has led to voluntary public health initiatives such as 'Change 4 Life', which emphasise to the public the importance of changing behaviours. However, they fail to address the social barriers to change and reasons for obesogenic environments. (13) These campaigns may widen health inequalities because obesity disproportionately affects people from lower socioeconomic backgrounds, (13) who tend to be less responsive to voluntary interventions.

Social medicalisation may also occur in the context of attempted harm reduction. For example, healthcare providers in Kenya have provided medicalised female genital mutilation (FGM), with the rationale that a minor 'symbolic' or 'psychological' procedure with proper infection control and anaesthesia will be safer than dangerous community procedures which would nevertheless occur. Although direct harm is minimised, indirect harm occurs as this legitimises the practice of FGM and therefore acts as a barrier to its reduction. (14) In this instance, medicalisation fails because it does nothing to alleviate the social harm and even worsens the oppression of women.

### **Disease-mongering**

'Disease-mongering' is a form of medicalisation where a party promotes the recognition of a new disease. There are myriad examples of diseases which have become medicalised and part of social discourse largely as a result of concerted pharmaceutical campaigning. These include erectile dysfunction, generalised anxiety disorder and attention-deficit hyperactivity disorder. (2) Although direct-to-

consumer drug advertising is not permitted in the UK, pharmaceutical companies exert an influence on what constitutes disease via physicians. Pharmaceutical sales representatives have been demonstrated to impair rational prescribing by physicians, leading to the favouring of non-generic versions of medications and the prescription of higher doses. (15) It is therefore not unreasonable to propose that pharmaceutical influence could increase physician medicalisation, which may not be in patients' best interests. To provide independent and objective information to patients, physicians must recognise their own biases and consider that they may medicalise even unknowingly because of pharmaceutical influence.

Medicalisation may also be driven by patients themselves. Social media and the Internet provide spaces for patients – identified or anonymous – to gather and share illness experiences. These can be especially beneficial for patients with rare diseases and those who are stigmatised. (16) However, self-diagnosis symptom checker websites often triage poorly and are risk-averse, (17) assuming the worst case scenario for symptoms, which may cause anxiety over benign symptoms. If this could lead to inappropriate self-treatment and distrust of mainstream medicine where it contradicts the collective experience of the group, we have a duty to understand and address the practitioner-patient gap that these spaces fill.

### **Holism and medicalisation**

Through understanding disease as a spectrum of experiences unique to each patient, holistic medicine attempts to reverse the 'medical gaze' described by the philosopher Foucault, (18) which medicalises states of being by reducing people to malfunctioning parts. Holism may therefore be seen as a method to reduce medicalisation by considering a patient's biological, psychological and social milieu. This is reflected in the General Medical Council's expectation of doctors to work in partnership with patients. (19)

However, it may be argued that holism, including newer forms such as personalised/system medicine and emphasised patient choice, paradoxically encourages medicalisation for the same reason. If disease is inherently part of the patient's life experience then that life experience is increasingly subject to examination, diagnosis, and alteration by medicine. This has been described as 'the medicalisation of health and life itself'. (20)

### **The role of medical students**

Medicalisation is a multi-faceted issue with various drivers, from healthcare practitioners and the pharmaceutical industry to social and political players. What role do we as students have in this process? As students and those just entering practice, we will experience a world of medicine which is becoming increasingly complex and specialised. For all we learn about diagnosis, we are taught little about over-diagnosis, over-treatment and medicalisation. Perhaps it is our role to observe the sources of medicalisation in our own practice: the next time you are in a clinic or on a ward round, you should consider the balance of the interaction and who instigates the medical or surgical approach – the practitioner, the patient, or an outside force?

We should engage with our patients and understand what motivates their perceptions of health and disease. We should be judicious in requesting investigations and

performing procedures and be equipped to understand and question the evidence base of clinical recommendations. It may seem self-defeating for doctors to limit the scope of medicine; however, we should keep in mind always that the patient is our first concern. We must take time to place the patient at the centre of care and consider the whole person.

Finally, we must also take care to consider the boundaries of medicine and to what degree it should influence our society, politics and our patients' lives. If medicalisation is inevitable, care must be exercised to ensure that it occurs in ways which benefit the human experience for all members of society.

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