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Medicalisation: Mapping of Everyday Lives on the Illness Continuum

Zeba Siddiqui

Introduction

There are certain terms which trigger a negative projection in one's mind. Medicalisation is one such term. It is often mentioned at places wherein one wishes to describe about theills of biomedicine. It often leads to pathologisation of conditions which are not even ailments. While physicians whotreat these patients are subsumed by their biomedical training, patients see no other way of addressing their discomforts which makes them submit to this regime.

Also, problematising normalcy, the concepts of sick and healthy being questioned persistently and most importantly defining altogether a novel idea of wellness are some of thefeatures of medicine being questioned in this section. The relevance of it amplifies since, doctors continue to use these standard approaches to decide what is a disease? And whosuffers from it?

Questioning normalcy includes, redefining relationships between signs, symptoms and illness and extending the reachof medicine to the daily lives of people. The patient's body alone now becomes an object of focus of medical attention. The bedside medicine proposed to study the patient in realms ofhis own settings, his home was the space wherein he was treated, focusing more on care than cure. While what 'hospital medicine' emphasized is putting the

patient in a neutral space, devoid of emotions and private surroundings so that the signs of the underlying lesion can surface properly and be examined accordingly. This dominance of the clinic as the fundamental center of health care provision furthered the practice of studying the people more as objects. This phenomenon istermed by Armstrong[1] as 'Surveillance Medicine'.

'Surveillance Medicine' basically means remapping theillness. The interaction between signs, symptoms are relookedat and the very nature of illness is redefined in this process. What is ill is no longer a prerogative of the patient to define, in fact whether a person wishes to classify himself as a patient, is also not his own choice. This authority now rests with the doctor, who structures what is ill and how ill a person is. It requires a blurring of the rigid categories of healthy and illand this type of medicine aims to bring the entire population under its network of visibility. 'A person (is) hung precariously between health and illness'. 'Surveillance medicine' separated the people on the basis of the symptoms and potential of deformities/ physical ailments they could potentially have, assuming that if people were normal they were not truly healthy. Armstrong says, surveillance medicine represented the realization of a new kind of health regime wherein the 'benevolent eye of medicine' could create medicalisation of everyday life.

It was primarily from the 1970s that sociologists began to examine the process of medicalisation and the expanding realm of medicine, writes Conrad[2]. They looked into the complex social forces that were responsible for medicalisation as it cannot be understood in a vacuum – factors such as social and political forces, class, age, race and gender need to be considered as well. Scholars have long pointed to social factors that have abetted medicalisation: the diminution of religion, an abiding faith in science, rationality and progress, the increased prestige and power of the medical profession and the American penchant for individual and technological solutions to problems. While factors like these do not explain increasing medicalisation over the past few decades, they have provided the contextual framework.

The new form of medicine therefore prospered on exileand encroachment of the personal lives of people, confinement of those people as patients in closed spaces of clinics and hospitals. The basic tactics of surveillance is no longer in a strict binary relationship between health and illness. Instead

to measure the same there exists, an ordinal scale in which healthy can become healthier and illness can survive in tandem with health.

Medicalisation

Borrowing from Moynihan & Cassels[3], it can be argued that the market tactics propagated by giant pharmaceutical companies, is constantly engaged in practices to enlarge their businesses. A popular manipulating technique is to persuade both the doctors and patients to seek medical help in cases wherein even non medication can come useful. Easy access tomedication leads to medicalisation of general problems, which could have been caused otherwise as a result of a few lifestyle changes instead of some physiological reasons. Only doctors alone cannot be stated responsible for excessive medicalisation practices, instead a lot of its credit should be given to the drugcompanies[4].

A process where aspects of everyday life come under thesupervision, dominion and influence of medicine, is appropriateto be deemed as medicalisation[5]. Zola also stated that undercertain conditions, virtually any human activity has the potential to be under the scrutiny of medicalisation. Medicalisation has also been projected by Peter Conrad[2] as thelicense of the medical profession to provide some type of treatment for a so-called medical problem. In other words, medicalisation as a concept can be defined as understanding a non-medical problem in medical idioms and within the ambitof a medical framework, usually as an illness or a sickness or a disorder and using a medical intervention to address or cure it.Through medicalisation the labels "healthy" and "ill" can beapplied to various aspects of daily human experience whichhad previously been outside the scope of medicine[5]. Medicalisation, can occur at three levels – conceptual/theoretical wherein a medical vocabulary or model is used to define the problem at hand; institutional/organizational where organizations may adopt a medical approach to treating aparticular problem in which the organization specializes and; interactional which is mostly the direct involvement of physicians who give a medical diagnosis and prominence ofthe physician comes under the limelight[6].

Usually, medicalisation is spoken of in a pejorative wayand has been used as a by word for all things negative about the influence of modern medicine on life and society. The term has largely become synonymous with the sense of a profession reaching too far - into one's body, mind, and even

the soul[7].

Conrad writes that sociologists have examined two important contextual aspects affecting medicalisation:

a. *Secularization*: Religion seems to have been nudged asideby medicine as the dominant moral ideology and institution of social control in modern societies. Medicine promotes secularization through its strict opposition to the public role of religion and instead, it advocates the medical regulation ofsociety. Many conditions have been transformed from sin tocrime to sickness of which homosexuality and fertility issues can be cited as examples. But the matter is not as simple as itappears to be and the interface of medicine and religion is morecomplex than a simple secularization thesis would suggest.

b.*Changing status of the medical professions*: The organization and structure of the medical profession has hadan important impact on medicalisation. There is a widespread monopolization of medicine over anything with the labels of health, sickness and/or illness.The medicalisation critique in the sociological literature initially arose from the perspectives of liberal humanism and Marxism in the 1960s and 1970s, writes Deborah Lupton[8]. Themain argument put forth by those who critiqued medicalisation was that in western societies, medicine and the medical practitioners had amassed a great deal of power and influence. Everyday problems were being viewed as diseases from the prism of science and medicine. Ivan Illich[9] was one of the most prominent proponents of this school of thought. He argued that '…rather than improving people's health, contemporary scientific medicine undermined it, both through the side-effects of medical treatment and by diminishing lay people's capacity for autonomy in dealing with their own health care'.[7] The critics of medicalisation also state that as the common man generally lacks medical knowledge, it puts him/her in a vulnerable position, allowing the doctor to exercise power and control over him/her.

Based on the work of Michel Foucault, this form of medical social control suggests that certain conditions or behaviours become perceived through a medical gaze and that physicians may legitimately lay claim to all activities concerning the condition. His understanding of power was closely associated with his idea of discipline, '…namely thatpower exists through the disciplinary practices which produce particular individuals, institutions and cultural

arrangements.[10]

Medicalisation subsumes within itself all the entire phenomena which lead to problematization of the normal, and endeavors to acquire everything within the ambit of pathology. Though this definition may not be entirely wrong, it can be enhanced a little, by arguing that it is not just medicine, or the profession of medicine itself which imposes this regime. Instead a lot many times, people who are assumedto be victims, hapless sufferers are in fact deliberately (if notwillingly) giving into this structure, so as to fall in line and find escapes from their miseries. This system which might belooking out for the possibilities of illness and the diseased, hasled to creation of an army of people who themselves are on alook-out for disturbances within their bodies.

These professional groups exercise a certain degree of superiority over the society and clients they function for. Incognizance with Armstrong's[11] view, it can be argued that professionals by virtue of specialized knowledge were a notchabove the people who did not possess those skills and these very skills set them apart for it would help them perform altruistic functions.

In the modern society, therefore, with the fascination towards professionalization, there was a hierarchical placement of all the vocations based on the expertise they held. So wasthe case with the profession of medicine. An occupation that subsumed within itself, all the modern characteristic to be a profession it enjoyed a specialized set of skills that gave these professionals a cut above their patients. Adding to this, profession of medicine is inherently seen as moral and altruisticand was considered to cater to the greater good of the society. These qualities, led the profession to seat itself at the highestposition in order of professions.

The primary reason why medicine is usually not suspected for doing any harm is because it is considered to be a moral calling. How medicalisation of our lives is being fed by rising power vested within medicine, is seldom looked at.It is pertinent to research whether there is a relationship between popularity of medical profession and the expanding arena of medicalisation which engulfs most of our everydaylives within itself. The line of thinking which equates medicinewith high degree of morality also places it on the plane of 'selflessness'. People engaged in this vocation are oftenconsidered to pay a potential cost by undertaking this act. The open ended time frame, the

vast arena of commitments and the vulnerability of losing one's social life to professional life, is what makes this occupation to be considered moral.

Due to this practice of attributing excessive morality to this profession, it is likely that people associated with it; assume a high position, even though they may not be adhering to its modules always. It therefore is not surprising when physicians acquire a superior, undisputed position and are often rendered correct in any relationship of doctor and patient. This dimension shall be discussed at length in the following section

Discussing the question about morality of medicine,McKay[12] introduces the idea of supererogation of the professionof medicine. In the profession of medicine, one is often considered to work full time, to be vulnerable to being subjected to a duty that is continuously involved in saving humanity and takes no cognizance of the personal commitments of people offering these services. Though it can also be said that due tointense amount of requirement, physicians are forced to workfull time and have no option but to oblige this commitment.

It is believed that a physician and a patient have a'fiduciary relationship'[10], one which is governed more by ethical principles and mutual trust rather than a contractual relationship. It is given that the professional has knowledge and skills much more than what the client possesses. The professional has the duty to use his expertise for the benefit ofhis client.

Problem arises in this relationship, when the former isentrusted with autonomy and the latter is completely convinced that whatever course the doctor might take, it will be for hisbenefit. Also, it becomes a matter of investigation, when the physician performs treatments on the patients without letting the latter participate in it due to the assumption of righteousness of his profession impressed upon him. The patient thus willingly surrenders his autonomy, and gives entire control to thephysician. If one were to say that medicalisation of even the slightest of daily activities is due to excessive powers vested in this profession, it can also be well argued that patients are partyto this regime and thus knowingly or unknowingly agree to bepushed through the medicalisation of their lives.

Medical Surveillance: a transition from 'how are you today?'to 'where does it hurt today?'

Given the obvious triumph of medicine, there is certainlyno matter of astonishment that it has come to rein our lives very significantly. In the course of this development withinthe purview of medicine, the equation of doctor and patientalso has altered a great deal. The essence of the relationship previously rested upon giving a descriptive account of one's wellbeing and/or suffering. 'This is now reduced merely to aminimalistic exchange comprising only of excerpts about one's body part(s) which cause discomfort or pain'[8] . The doctorand the patient both wish to reduce the talk only to 'where ithurts'.

Normalcy perpetuated the possibility of abnormalcymeaning that the patient is inseparable from the person.The eye of an observer is the most fundamental means to keep acheck of the people being observed. This "gaze" is a finelycalculated, appropriately measured eye of observation that iscoupled along with the expert's medical language. This 'gaze' basically helps the physician establish a new relationshipbetween the knowledge he has accumulated and the personwhom he treats as a field of experiments for that knowledge.

Foucault[8] in his seminal work argues about the significance of this very gaze, which in his opinion helps biomedicine to take its agenda to an advanced level. "Gaze" isessential to objectify a human into patient for it helps arrangeall the discomforts of a person into neatly organized categories.This categorization, the 'Nosological order', as Foucault pointsout, happens at every level. Right from the time when a person expresses feelings of a certain sickness, it is converted intosymbols of medical language.

This in itself can be seen as the first step in violation ofthe subjectivity of a person, who is now dwarfed into a merecase by the reductive prowess of medicine. The patients arenot entirely same, though they differ from each other as far as this nosological order lets them be apart from the other sufferer and at the same time the difference is signified by the similarity that one patient shares with a fellow patient with similar symptoms.

Free of the burdens of language and any interactional contract between the doctor and patient, a gaze, serves in a medical discourse a purpose providing a mechanical structure to the same. The relationship established through the

'gaze' is thus non reciprocal one, giving primacy to everything non verbal and observed, lending no curious ear to the plight of the sufferer for he is just another case in eye of physician.

The sufferings of a person then become secondary, and he is subtracted from the internal fact representing the disease. The presence of a doctor and patient as persons, are disturbances that are to be neutralized, since it might come inthe way of observing and documenting facts. The point that should be noted here then is that doctor and patient stand achance to lose their importance as a person who might have more than just facts to give.

The whole relationship of doctor with his patient is redistributed, for one assumes an extremely high position and the other absorbs a much objectified position. If one were tolook at it, the patient is simply a means to further the objectivesof the ambitious researches that biomedicine aims to conductthrough the professionals. Therefore, disintegrating the personfrom the problems and deciphering the ailments out of it,epitomizes the intelligence of the doctor, it is 'the compass of adoctors success'[8], for the quality of his knowledge is measuredby the exact knowledge of the disease.

Absolute silence of all forms of language at the sight of a patient, sometimes also leads to silence of the touch and sensitivity that a doctor needs to offer to his patient. Also not all persons are a field of medical investigation which they areoften reduced to. The neutral domain of a clinic renders anemotion free character to the relationship of the two, which numbs any scope of humane and compassion laden treatment.

After thoughts for the changing doctor-patient interactions

One of the most salient features of medical care is the dialogue and encounter between doctors and patients. The requirements of diagnosis, treatment and follow up are met by collective efforts of doctors, patients and other helping paramedical staff facilitated by the health institutions. The roles therefore played by doctors and patients in this interaction become very significant. The objective of this section is to demonstrate how, the afore mentioned interaction has undergone a major transformation, also another idea is to establish the importance of this evolving relationship in contributing to the medicalised lives people are living. The said unsaid hierarchy that is

invariably assumed, the reasons for which were mentioned in the preceding section, has a major hand in according undisputed position to the medical staff and physician. Hence, it should also be pointed out in whatways this authority comes to be manifested in reality and howis it perceived by people through experiences that they have with the medical world. Another focal area here is to look atthe importance of trust that is bestowed upon the physicians, and whether there is feeling of betrayal on part of the patients when dealing with the physicians. It should also be interesting to note whether excessive insistence upon the biomedical approach, which being factual, leads to sidelining of a patientsstory. And does a patient feel himself heard or ignored in course of this encounter?

A patient is an equal partner in a medical process of curing a disease and cannot be simply viewed as a recipient of medical care since it is the patient who first experiences andreports about a discomfort that he feels with his body. A doctor becomes salient when he is consulted to identify and rectify the given problem reported by a person. The doctor hence becomes a specialist who has the expertise to categorize acertain feeling of illness into a medically defined disease. It is therefore interesting to note how the same interaction can provide an insight in a two fold manner. One wherein the two talk about what could be or what is potentially problematic with the patient's body and another in which the two can exchange details about not just the pain of the body but experience of the sufferings too. Mathew George[13] opines that given the varied hues of a doctor patient relationship, it can be classified into four broad categories namely; paternalistic, informative, interpretative and deliberative models. A 'paternalistic model' , like its name suggests, puts the doctor inposition of an expert, just like an elder family member or maybe a priest, who decides the best possible treatment for a patient and the patient in return should be extremely obliged for this gesture of favor showered upon him. Next, the 'informative model', George[11] argues, can be referred to as 'scientific engineering', which requires translating a patient's regular, lay language into technical codes through usage of the physician's expertise. The physician assumes the role of a counselor in the interpretative model, wherein he helps a patient, to understand the priorities of the treatment to be done and to reach a certain decision about the same. While the final, 'deliberative model', a physician, George[11] says, spreads out all the possible options before the patient for him to understand and choose according to his comfort.

Common to all of these approaches is the factthat the physician acquires a superior position in the contactand tells the patient what to be done or what can be done. Ittherefore does not come as a surprise that for a doctor it becomesvery easy to influence the patients decision and to impress hisown superiority in the discourse overall.

But the problem arises when in the said relationship not only hierarchy seeps in too deeply but also when the patient is solely considered as a human body to be studied. Medicine needs an object that can serve as its site of scrutiny and can further the process of research and study related to it. Now, if a doctor patient relationship particularly thrives onobjectification of the human body as a specimen to learn andwrite about diseases that plague it, it is needless to say that the humane side of a person is easily forgotten. The biomedical model worships this process of viewing human body of comprising only of anatomy and devoid of any subjectivity. As Duffy[14] documented on the completion of a hundred yearsof the Flexner Report that transformed the face of medicale ducation, explains well how, the report led to diminishing of charity hospitals and care centers in America and establishment of a research based model of medical education. The report isjust an exemplar to understand how scientific knowledge was embraced at the cost of giving up the more human and personal side of a medical story. It helps us decipher how revering arational system led to establishing of a strict regime that preferred looking at humans more as a case study than as a person. Many medical researchers often argue in favor of this objective claimingthat unless there is an objective approach, it is impossible toseparate mind from body and to observe the latter.

A similar case is demonstrated in Margaret Edson's Pulitzer Prize winning play 'Wit'. The play revolves around an English professor, Vivian Bearing, who is also a cancer patient. The story is about her navigation through the ordeal of going through a life threatening disease amplified manifolds by the treatment she receives from the doctors and the hospital. She is taken up as a case study by her doctors for she represented a 'strong' woman who was devoid of emotions or any relatives who would worry for her. Her doctors therefore considered her as a potential experiment field and tried to useher to come up with competent findings for cancer related research. Though Vivian sportingly agrees to the proposal and offers her body for experimental use,

but as the play progresses, she feels betrayed and broken as a patient for she expected a caring atmosphere which was replaced by a very mechanical setup. As a literature scholar who would dissect prose and poems down to the last comma and alliteration, the doctors now turned her into an object to be dissected down tomere combinations of cells. Vivian's body was used as a slate to write upon, even the final act of the body, dying, is followedby autopsy, which ceremonially marks the very last attemptto encrypt the patient's body.

Freidson[15] argues that medicine has come to represent the archetypical institution of the western culture which justlike religion has started to bind people in its dogmas and these dogmas , just like religious dictums are largely unquestioned. He goes on to add, that the soldiers of this army of medicine (patients and physicians alike) are marching towards a common goal, which are determined by organizational demands. As mentioned earlier, physicians often have the privilege to define what illness is. They do more than just performing the function of diagnosis and prescribing medicines accordingly, by defining illness, physicians control what aperson should feel; what he should be defining as pain and ailment and therefore rest his complete body for scrutiny whenin presence of a doctor. Doctors on the other hand tend to impress their perceptions about reality onto the lives of a patient. Biological illness is different from what its accepted social definitions are, and physicians tend to act as "moral entrepreneurs"[13] who are involved in defining socially agreed upon parameters of illness, often shaping and destructing a patient's beliefs about his own body. In the process of acting upon a given greater altruistic motive, the doctors now, tend to exercise a totalitarian kind of a regime upon the society. The unquestioned faith bestowed upon them leads to low level of accountability and regulation amongst them and higher degree of autonomy at the same time. As Larson[16] correctly argues,'In this light the power and status of medicine could simply be interpreted as the result of skillfully exploiting a marketing opportunity in health care.'

The labeling theory model flagged by Freidson[13] very appropriately highlights the problem within this kind of unchecked autonomy assumed by medicine. The professional is in a position to label any kind of deviation within a given situation as a form of illness so much so that, it creates a moral binding upon the patient, to feel guilt ridden for having departed the norms.

It must therefore be questioned whether expertise is fast becoming a

cape to cover all the ills within the profession that discover ills, whether knowledge has been assumed as an alibi for power and privilege. The decision about a patient and hislife should involve the patient himself too, even though hemight be a lay person, but it is only unfair to take into consideration what the scientific facts tell and not what the person's personal circumstances have to convey. A doctor is certainly qualified enough to identify the bodily problems that a person suffers from, to classify them appropriately and takea suitable medical course to treat it. But, the patient in himself is a telling tale of many psychological, social and cultural traits that physiology might be insufficient to transmit and therefore, a doctor's expertise, should meet the personal narratives ofthe person he is attending. It certainly cannot be discounted that this profession is indispensable, but it should also be taken into account that its take on illness is cause of concern. Havinga tendency to define everything in terms of pathology and bodily deformity, it certainly is important to investigate how inclination towards medicalisation is amplified by the professionals. The supremacy that this aura of beneficence and morality entails, lets the profession enjoy an undisputable position, the subjectivities of a patient and his plight are often ignored under the magnificence of these virtues. The authoritative and paternalistic doctor patient relationships arenot equal and often give the former an edge over the latter. This skewed relationship can also be regarded as one of themain reasons why narratives and subjectivities are given a far secondary position in a clinical encounter as opposed to the biomedical approach followed religiously by the doctors.

This change in the profession is the precursor to thenew kind of dialogues that occur between the doctor and patient. The linguistics has probably shifted from the exchangeof pleasantries and personal wellbeing to the sophisticated interaction guided by medical parlance. The new age communication thus spares only that information which isvital in diagnosis and treatment.

Greenhalgh[17] who assimilates her account as a patient echoes the above mentioned views about shift in a doctor-patient relationship. When she approached a highly celebrated doctor, recommended to her by her friends, she had already entrusted him with immense awe and reverence. What followsin her account is a testimony of complete robbery of this trust, since the doctor pays no heed to Greenhalgh's personal accounts and resultantly she feels unheard and helpless. The lady repeatedly encounters discomforting signs in her body, but she sidelines them to continue honoring the treatment

prescribed by the doctor. She argues she was 'coaxed' into becoming an obedient patient by her doctor.

Doctors often opt for rhetorical arguments to convince a patient. They may not necessarily lie, but their statements are often exaggerated truths that are embellished with factual jargons of the biomedicine, which often leave a patient withoutany defense to his rescue. The doctors thus, exploiting their humanitarian and moral image, tend to work out certain conversational gambits which help them to change a reluctant person into a docile and complying patient. This also includesheavy loss of personal narratives for often doctors have noroom for them.

The clinical encounters often lack a dialogue, a discourse that pools in languages of both a patient and a doctor. Toborrow from Foucault's[8] explanation, a clinic is like a meeting point of doctor and patient. But it is necessary that this meeting point leads to a confluence of thoughts of both of them. The 'observing gaze'[8] that Foucault points out to, is nothing but a still, considerable look at a person by the doctor, who notonly cures but cares. One who is silently observing and rests his theories and expertise quietly when in presence of an ill person. The art of gazing therefore must be accompanied witha zest to observe by listening peacefully and absorbing whatever a patient has to offer. It is not to treat the geography of a human anatomy as a means to quench one's thirst for authority and expertise in research.

What does a patient then really demand from the medical science? Does he want to be treated like human being? Ordoes he wish to be cured more than being heard as a person?.The answer can be seen as a combination of both of these polar opposites. Such questions signal the dualistic model of the biomedicine which treats mind and body as separate entities. What is needed is not a separatist regime trying tosingle out symptoms which are only physiological but a model that efficiently also looks at each patient as a person, someone who has a background to offer, whose illness does not necessarily stem from anatomical issues alone but social cultural & personal hardships too. One of the main criticisms that arise is that whether we can consider that particular 'something' that lies outside the bounds of the flesh/ body landscape. The constructs like 'healthy' or 'diseased' body can very well

be created by experts who treat this body, and it's needless to say that the constructions can happen to suit their own purpose. Thus what is considered diseased and unhealthy must also take into cognizance a person's opinion.

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