

Medicalisation in the 21st century: Introduction

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What is medicalisation? What are its causes and effects? Who benefits from medicalisation, and who is harmed? What, if anything, should be done about it? Answers to these questions would have seemed quite obvious in the 1970s, when the term entered academic and medical publications: medicalisation, the expansion of medical authority into the domains of everyday existence, was promoted by doctors and was therefore a force to be rejected in the name of specific kinds of liberation. Ivan Illich's 1975 book, *Limits to medicine: medical nemesis*,¹ was the most influential early example of this usage of the term medicalisation. Illich, a philosopher, argued that the medical establishment posed a "threat to health" through the production of clinical, social, and cultural "iatrogenesis".¹ For Illich, Western medicine's notion of issues of healing, ageing, and dying as medical illnesses effectively "medicalised" human life, rendering individuals and societies less able to deal with these "natural" processes.¹ Illich's assessment of professional medicine, and particularly his use of the term medicalisation, quickly caught on, as critiques of the expansive categories of illness and health appeared throughout a vast array of professional literatures throughout the 1970s and 1980s.^{2,3}

30 years on, the definition of medicalisation is more complicated, if for no other reason than because the term is used so widely: a Google search for "medicalisation" in 2006 yields more than 358 000 hits. Many contemporary critics position pharmaceutical companies in the space once held by doctors as the

supposed catalysts of social transformation. Titles such as *The making of a disease*⁴ or *Sex, drugs, and marketing*⁵ critique the pharmaceutical industry for shunting everyday problems into the domain of professional biomedicine. At the same time, to suggest that society simply reject drugs or drug companies in much the same ways Illich suggested it "liberate"¹ itself from the medical system is implausible. The same drugs that treat deviances from societal norms also help many people live their lives. Even scholars who critique the societal implications of brand-name drugs generally remain open to these drugs' curative effects⁶—a far cry from earlier calls for a revolution against the biomedical establishment.⁷

The physician's role in this present-day notion of medicalisation is similarly complex. On one hand, the doctor remains an authority figure who prescribes pharmaceuticals to patients. Whereas on the other, in the USA at least, ubiquitous consumer-directed advertisements instruct patients to ask for particular drugs by name, thereby creating a conversation between consumer and drug company that threatens to cut the doctor out of the loop. The role of patients in this economy has also changed. Once regarded as passive victims of medicalisation, patients can now occupy active positions as advocates, consumers, or even agents of change.

In June, 2005, an interdisciplinary group of scholars gathered in New York City, USA to discuss the clinical, philosophical, and political implications of medicalisation. The group's central question was whether, in the industrialised world, medicalisation remains a viable notion in an age dominated by complex and often contradictory interactions between medicine, pharmaceutical companies, and culture at large. Participants represented a variety of disciplines, including psychiatry, sociology, anthropology, history, critical race theory, and gender studies. As such, topics ranged from the economics of medicalisation to the creation and perpetuation of medicalised forms of identity and citizenship. The next five papers in this series are those that were presented at the meeting in New York.

Conflict of interest statement

We declare that we have no conflict of interest.

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Patient empowerment and the dilemmas of late-modern medicalisation

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In *Medical Nemesis*,¹ perhaps the most influential definition of medicalisation ever written, historian-philosopher Ivan Illich argued that by overextending its scientific and cultural authority, modern medicine had itself become a threat to health, a fount of “doctor inflicted injuries” and “iatrogenic disease”.¹ Although Illich’s 1975 book focused mainly on the role of the medical profession in creating these problems, he suggested that the ill effects of medicalisation might well be reversed by the actions of a long “passive public”, now beginning to recover its “will to self-care”.¹ The deepening crisis of modern medicine presented new opportunities for “the layman effectively to reclaim his own control over medical perception, classification, and decision-making,” a “laicisation of the Temple of Aesculapius” that Illich believed held great promise for the reform of modern medicine.¹

Read afresh in 2006, Illich’s emphasis on laicisation seems remarkably prescient in some ways. Since the 1970s, patient activists in the USA and Europe have aggressively asserted their claims to be regarded as experts on their own illnesses and to play a more active part in health-care decision-making. Patient initiatives have resulted in monumental changes in the practice of medicine, including the legalisation of abortion, living wills, hospice care, hospital bills of rights, lumpectomies, experimental clinical trials, and expanded access to a vast array of consumer health information, to name only a few examples. Although many physicians initially resisted the idea of increased patient participation, lately they have become reconciled to, sometimes even enthusiastic about, the idea of the patient as partner. In developed countries, patients are now expected to take an active role in their care, and to be treated as important stakeholders in policy debates.²

Yet contrary to Illich’s 1970s optimism, increasing the role of patients in clinical decision-making has not been the solution for the many problems that beset late modern medicine in developed countries. The advent of patient-centred medicine has come at such a troubled point in history that its achievements are in danger of being negated. Although patient initiatives have secured the expansion of some kinds of choices and safeguards, especially for the educated and affluent, they have been

offset by growing demands for cost containment and market discipline that have limited the autonomy of both physicians and patients. Expectations of doctor-patient partnerships have been complicated not only by persistent asymmetries in the knowledge and power bases of the two participants, but also by contradictory pressures to limit costs yet also to secure the best and usually most expensive treatments.³

In the face of such complications, to revert to an oversimplified cast of heroes and villains, and to replace the doctor blaming of the 1970s with patient blaming in the early 2000s, is tempting. Ignorant, irrational patient-consumers provide an easy explanation for the persistence of problems: they refuse to believe in the truths revealed by science or economics, they resist paying what services are worth; they seek the wrong services (Botox, breast implants) and ignore the prudent action (smoking cessation, healthy diet). In the new era of collaborative medicine, patients have nowhere to hide.

Perversely, whereas patient choices are often denounced as expensive and irrational, claims to be acting on behalf of patients’ true interests have become so promiscuously asserted as to be almost meaningless. Stakeholders with diametrically opposed policy positions present themselves as the patients’ best friend: the drug company justifying its use of direct-to-consumer advertisements, and the consumer groups calling for their elimination; the insurance companies imposing benefit limitations, and the doctors and patients who challenge them; the policy camp arguing for medical savings accounts, and the policy camp opposing them. As all the major players in current policy debates justify their positions in the language of patient empowerment, that language has become essentially bankrupt.

Yet for these very reasons, we need to scrutinise the conception of patient-centred medicine in an era of perpetual health-care crisis. Returning to a pre-1970 model of paternalism is simply impossible; the only way forward lies in improving on the collaborative models that have emerged in clinical and policy settings over the past two decades. Future debates need to focus not only on the values but also on the processes by which patients’ interests are defined, measured, and protected.