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MEDICINE AND MEDICALIZATION:[1] A RESPONSE TO PURDY

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ABSTRACT

Many feminists are critical of the practices and institutions that medicalize people's lives, especially the lives of women and other members of marginalized groups. I argue that this critique does not necessarily imply a rejection of medicine. I give a brief analysis of the concept of medicalization that supports the view that one can desire medicine without desiring medicalization. I then discuss the relations among what is considered natural, socially constructed, and medicalized.

The relationship between medicine and medicalization needs some untangling. Many feminists are extremely critical of the practices and institutions that medicalize people's lives, especially the lives of women and members of other marginalized groups; nevertheless a critique of medicalization does not necessarily imply a rejection of medicine. Laura Purdy is among those in feminist bioethics who carve out a middle path: she wants to keep the baby – scientific medicine – while we throw out the bath water of overly pervasive medicalization. I support Purdy's general stance and agree, as well, that more work needs to be done to clarify relationships among the basic concepts under discussion. To the latter end, I will explore two sets of concepts briefly:

[1] An earlier draft of this paper was given in response to Laura Purdy's paper 'Medicalization, Medical Necessity and Feminist Medicine' during the Feminist Approaches to Bioethics section of the International Association of Bioethics Conference in London, September 2000. An anonymous reviewer provided helpful comments on a later draft.

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I. The contrast implicit in medicalization and its implication for our ability to reconcile a desire for medicine with a critique of medicalization.
II. The relations among what is natural, socially constructed, and medicalized.

I.

First, let's keep in mind that a stance in which one critiques medicalization, but desires medicine now and then, is not an unusual kind of stance in many of our lives. Feminists, as well as anyone else who is at all reflective, often find ourselves in positions that require distinctions and nuanced thinking. For example, many people oppose the corporatization of the academy, but like or even seek an occasional corporate donation for worthy academic needs. People who critique capitalism still sometimes invest in stocks or bonds. We buy car or homeowners' insurance while objecting to the practices of the insurance industry. Some feminists disapprove of the institutions and industries that produce the full range of sexually explicit materials, yet distinguish pornography from erotica in order to separate the bad prurient material (which we don't like) from the good prurient material (which we do). Do these kinds of distinctions make us inconsistent or hypocritical? On the whole, no, they make us reasonable people and nuanced thinkers (although I confess to hearing a voice in my ear asking whether 'nuanced thinking' is just 'inconsistency we like'). While I do not suggest that these examples are all strictly parallel to each other, they serve to remind us of some of the many kinds of value-laden situations that require distinctions in our daily lives.

Yet there is a conceptual facet to an apparent conflict between the desire for medicine and the critique of medicalization that makes it differ from some of the examples mentioned above. Before discussing it, however, let's remind ourselves of the reasons for the apparent conflict. We want medicine there when we need it or find it potentially useful; after all, it sometimes helps us save lives and prevent or cure disease. However, we don't want human beings, either individually or as communities, to be subject to medicalized thinking and institutional practices when this kind of thinking or practice is oppressive, misguided, inappropriate, and so forth – and that is a lot more of the time than many people would like to believe. Although all people are subject to medicalizing practices, medicalization is a feminist issue because women, along with other marginalized people, are

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particularly disadvantaged by it. Medicalization is a means of social control that interlocks with other practices of domination to increase the damage caused to the lives of marginalized people. In addition, insofar as marginalized people by definition 'deviate' from the norm, standard features ('natural' processes) of their lives stand at greater risk for medicalization.

Let me explain the conceptual features of medicalization that lead me to find no inconsistency, feminist or otherwise, in opposing medicalization in general while still accepting the value of medicine in a number of cases – even in a highly medicalized area of life. The notion of medicalization implies multiple competing or potentially competing practices, institutions, or conceptual models. I do not mean that it is always explicit in the definitions of 'medicalization.' It is not, for example, in Conrad's frequently cited definition: medicalization includes seeing 'a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to ''treat'' it.'[2] There's nothing stated here about medicine's encroaching on another kind of conceptual model or practice, nothing that notes that medicine's norms and metaphors crowd out useful norms and metaphors previously used in that arena.[3] However, we don't tend to use 'medicalize' as long as medical folks use the tools of their craft on states, events or processes that we in our culture already see as within the medical model, e.g., cancers of various kinds, intestinal flu, broken bones, etc. It is not that we would be saying something false if we did, but we'd either be saying something boring or perhaps be implicitly starting to engage in a cross-cultural contrast between a Western technological culture that sees cancer as clearly a medical problem within a medical model and another culture who sees it (or has seen it in the past) under a model of punishment or of dishonor.

This seems to me to be an uncontroversial conceptual point. The cases in which it makes interesting sense to talk about

[2] Peter Conrad. Medicalization and Social Control. *Annual Review of Sociology* 1992; 18: 213–232; 211.

[3] Other characterizations have explicitly incorporated the ever-expanding nature of medicalization (which implies more clearly a conceptual contrast); see Peter Conrad and J. Schneider. Looking at Levels of Medicalization: A Comment on Strong's Critique of the Thesis of Medical Imperialism. *Social Science and Medicine* 1980; 14A: 75–79, and Irving K. Zola. 1978. Medicine as an Institution of Social Control. In *The Cultural Crisis of Modern Medicine*. John Ehrenreich (ed.). New York. Monthly Review Press.

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medicalization are those in which there is a plausible or potentially plausible contrasting model available. The examples are familiar to readers – the contrasts between sin and sickness, or between natural, normal, or everyday on the one hand and diseased/potentially diseased on the other, and so on.

What is the value of recognizing the implicit contrast in the term 'medicalize'? First, it lets us feel more sanguine about resisting medicalization at the same time we use medicine when it seems appropriate to us. Resisting medicalization, at a minimum, includes not approving of the way in which medical models have taken over an area previously conceptualized under another model. Recognizing the implicit contrast means that we can want to avail ourselves of medicine without wanting to avail ourselves of medicalization. Someone can even *be* a medical practitioner without 'medicalizing' (although, given the state of Western medical education, this might be difficult).

Of course, the harder cases are ones that interest Purdy, cases in which the medicine one wants occurs squarely within a 'medicalized' context, for example, sexual activity, reproductive and post-reproductive processes, etc. A middle-aged professional woman who relies heavily on her memory in her work might welcome hormone replacement therapy that revives her memory at the same time she rejects the framework that has turned menopause into a 'hormone deficiency disease.' A gay man might be highly mindful of the damage medicalization has done to gay men and lesbians in particular as well as the ways in which it distorts sexuality in general, but he might still want a viagra prescription. I take it that these kinds of cases fall in the category that Purdy cites toward the end of her paper – the desire for medicine to 'treat' something that is not a disease. But even in these cases, one doesn't desire or approve of medicalization; one just understands that medicalizing sex was the precondition for the production of the viagra one desires. I am comfortable making this distinction, but recognize that others might object. Objectors could, for example, see this kind of case as analogous to the legal doctrine that excludes evidence obtained in an illegal search as 'fruit of the poisonous tree.' However, I prefer to see it as an application of an inverted variation of the doctrine of double effect: one does not necessarily desire a precondition of the desired result.

Note that I am not saying that 'medicalizing' is value-neutral. My conceptual point about the implied contrast in medicalization implies nothing about the values implicit in medicalization. In fact, we must be clear about, even very wary of, the values in our cultural/political practices – what Kathryn Morgan refers to

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as the macro- and micro-institutionalizations – as well as the conceptualizations utilized by medicalization.[4] Yet a set of practices, institutions, and conceptualizations can have seriously negative value and still spin off something good. A very bad war or unjust regime can do great damage, but can result in a few nifty inventions, great works of art, or a flourishing of comradeship and community.

In spite of the fact that good can come from not-so-good institutions or practices, and in spite of my affinity for an inverted doctrine of double effect, I am still worried about the problem of complicity. The inverted doctrine of double effect cannot excuse the middle-aged woman and the gay man from all complicity with medicalization because it functions only at the level of their beliefs and desires. Their *actions* might well lend respect or credence to the medicalization they sincerely claim to reject. I suspect that once again we will find ourselves in situations that require distinctions and nuanced thinking.

Let's make our middle-aged woman a tenured professor in order to try to minimize issues of age discrimination. Suppose she and those who accuse her of complicity, feminists all, agree that a cultural adoration of youth coupled with other typical forces for medicalization lie behind the cultural 'push' for both hormone replacement therapy and cosmetic surgery. Nevertheless, her critics are much more likely to be sympathetic to her use of hormone replacement therapy than they are to accept her desire for cosmetic surgery (although they may well fully understand her dislike of wrinkles, sagging skin, and thickening waistline or thighs). The professor herself is also less likely to be morally conflicted about her use of hormones. But 'nuances' or not, the issue of complicity does not go away completely when we are squarely within a medicalized context. Only if we have some success in transforming a medicalized context to rid the particular practices of medicalization of their negative value can a participant have extremely 'clean' hands. Purdy, in agreement with Morgan, thinks that transforming medicalized contexts for our own empowerment should be one of our long-range goals.[5]

[4] Kathryn Pauly Morgan. 1998. Contested Bodies, Contested Knowledges: Women, Health, and the Politics of Medicalization. In *The Politics of Women's Health: Exploring Agency and Autonomy.* The Feminist Health Care Ethics Research Network (Susan Sherwin *et al.*, eds.). Philadelphia. Temple University Press.

[5] Purdy. Medicalization, Medical Necessity and Feminist Medicine, this copy of Bioethics, pp. 248–261.

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II.

Let's now turn to the relations among what's natural, socially constructed and medicalized. I concur with Purdy's positions that feminists should (a) take a critical stance in general toward dichotomies, (b) be wary of terms such as 'natural' or 'normal' in various contexts, and (c) attend more carefully in particular to their own use of 'natural' and 'normal' in drawing a contrast with 'medicalized'. Although it clearly shows intellectual and political progress to think about medicalization in a way that rejects an oversimplified, naïve contrast between the natural and the medicalized, it seems likely that the relations among these two concepts and the concept of social construction will be extremely untidy and complex. Because this is not the place to do a lengthy analysis of the three concepts, let me instead focus briefly on a few implications of some examples of social construction.

Start with the assumption that our bodies are in part socially constructed, that is, cultural norms are inscribed on our bodies and embodied in them in very complex ways. Arguments from Foucault and a number of feminists cited by Purdy have long been in the literature and are accepted by many feminists and nonfeminists alike.[6] However, even if we take this as a starting point, there are still several points to be made. First, this does not mean that bodies and their processes are also not 'natural' or 'normal' in some perfectly acceptable sense. For example, women naturally menstruate and go through menopause in a way that women do *not* naturally have in vitro fertilization, tummy tucks, or breast augmentation or reduction. 'Natural' in this context means little more than if not tinkered with, women usually do this.[7]

Second, the fact that the 'natural state' is not a clear, distinct category in direct contrast with medicalized thinking implies very little. There are a number of kinds and facets of social construction: not all social construction is medicalized construction. The female form was socially constructed long before the possibility of contemporary cosmetic surgery appeared on the scene; foot binding and corsetry spring to

[6] See Purdy. op. cit. notes 13–22.

[7] Consider how the contrasts might shift if one used another of the many possible meanings of 'natural': found in the physical universe outside the human species, very common, not artificial, free from human intervention, in accordance with something's purpose, or in accordance with the descriptive laws of nature.

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mind. Or consider childbirth. Although 'natural,' childbirth has long had a wide range of social constructions: think of the many different attitudes about childbirth and power that long predated the medicalization of childbirth. So, as we begin to think about the complex relations among what's natural, socially constructed and medicalized, we will need to remember the differences between medicalization and other kinds of social construction.

Third, we need to disentangle a number of other social factors that play into the negative constructions that surround or at least accompany medicalization: commercialization, risk management that may or may not be medical, etc. Let me use an example to shortcut an explanation. I recently visited a lesbian couple and their newborn baby in the hospital. It had been a highly medicalized pregnancy and delivery from start to finish. Yet the most salient 'social-or-socially-constructed' factor that hit me as I held their newborn daughter, was *not* anything particularly medicalized, nor even that the baby had two mothers and a sperm donor – it was that a newborn baby was wearing a security ankle bracelet that would set off an alarm if she left a specified area. (Was the baby under house arrest?) The ankle bracelet does not exemplify 'the medical gaze,' but the 'panoptical gaze,' the need to monitor continuously for reasons of security and risk management.

The point of these few examples is to suggest how complicated it is going to be if we want to give a positive analysis of the relations among the various kinds of social construction, medicalization, and what some consider natural. The important thing is that our expanding map of the complexities is less false and misleading than was the earlier oversimplified contrast between natural and medicalized.

Let me close by reiterating my general agreement with Purdy, Morgan, and others cited by Purdy who recognize the complexities of the issues of medicalization.[8] In varying ways these feminist philosophers see the need to transform the culture of medicine and to critique medicalization while they recognize the complex character of medicalization and its equally complex philosophical and political implications. For example, Morgan cites a range of ways that women's health advocates interact with the health care system: sometimes resisting *totalizing* medicalization of processes or states (e.g., pregnancy), other times fighting

[8] See Purdy, op. cit. n. 14–16.

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for demedicalization (e.g., sexuality), fighting for access to medicine (e.g., prevention of cardiovascular disease), or fighting for different medicalization of areas (e.g., premenstrual distress).[9] Purdy makes an important addition to these strategies by her call to transform the culture of medicine. Although Purdy's essay is more utopian than Morgan's, many of their eminently sensible strategies seem consistent, complementary, and very valuable.

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[9] Morgan, op cit. 110. I replaced Morgan's 'access to medicalization' with 'access to medicine' in order to be consistent with my usage in this paper. In this literature 'medicalization' is sometimes used broadly (and, I think, misleadingly) to cover both medicine and medicalization.

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