

The growing definition of illness

Reno Gazette-Journal / RGJ.COM

Sunday, July 21, 2013

One won't be able to watch the British Open this weekend without being subject to a barrage of commercials promising hope for men possessing the courage to discuss erectile dysfunction or "low T" with their family physician. These marketing efforts offer a benign reminder of the steady march of "medicalization" and related attempts to widen the boundaries of treatable illness.

Medicalization refers to a process by which ordinary human problems come to be defined as medical problems, typically in terms of disorder or disease, and consequently requiring medical intervention and remedy.

Sociologists have been quick to point out that medicalization, like other social processes, is neither an inherently good nor bad thing. Rather, medicalization refers to ordinary problems and behaviors that have been annexed by the apparatus of modern medicine. Most experts on medicalization contend that there is abundant evidence for the expansion, rather than the contraction of medical jurisdiction over the last half-century.

Examples from the long and growing list of "medicalized" conditions include attention deficit/hyperactivity disorder (ADHD), male pattern baldness, social anxiety disorder, menopause, chronic fatigue syndrome, normal childbirth, social anxiety disorder or social phobia, sleep disorders, alcoholism and a number substance abuse disorders, erectile dysfunction and related male performance issues, post-traumatic stress disorder (PTSD), an assortment of body image conditions and disorders, and andropause or "male menopause" resulting from low testosterone.

Many forces are responsible for the onward march of medicalization. For example, in his recent book "Saving Normal," Dr. Allen Francis argues that the recent publication of the Diagnostic and Statistical Manual of Disorders (DSM-5), the "bible of psychiatry," holds the

potential of turning our current diagnostic inflation into hyperinflation by converting millions of additional “normal” people into “mental patients.” In the DSM-5, he contends, normal grief become “Major Depressive Disorders,” temper tantrums are now “Disruptive Mood Disregulation Disorders,” and worrying about a medical disorder itself will carry the medicalized label of “Somatic Symptom Disorder .”

A more controversial addition to the expanding list of medicalized conditions is obesity. Last month the American Medical Association’s (AMA) House of Delegates endorsed the medicalization of obesity by classifying obesity, formerly considered a major risk condition for multiple chronic diseases such as diabetes, as a disease. While the AMA’s decision won’t immediately change medical practice, classifying obesity as a disease will hasten the prospects of third-party payments for physician-provided or physician-supervised treatments for obesity.

Again, the medicalization of obesity is not necessarily a good or bad thing. In fact, its medicalization could reduce the discrimination and stigma faced by many overweight individuals by emphasizing those causes of obesity beyond the individual’s control.

However, elevating obesity to disease status has enormous health policy implications for how we think and deal with the obesity epidemic. In particular, the medicalization of obesity diverts critical attention and resources away from preventive measures tackling the ubiquitous features of our social and cultural landscape giving rise to our increasingly obese population. In particular, the medicalization of obesity represents one more instance in which we have turned our collective focus from upstream determinants of health, such as the social and cultural forces propelling the overconsumption of sugary and fatty foods, to downstream medical measures that are both costly and that do not address the roots of our worsening obesity epidemic.

John Packham, PhD is Director of Health Policy Research at the University of Nevada School of Medicine and Past President of the Nevada Public Health Association.