Medicalisation

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Medicalisation is defined as a process by which non-medical problems become defined and treated as medical problems usually in terms of illnesses or disorders.

Initially all deviant behavior were described as sin or criminal behavior and religion had full control over how to punish such deviant behavior. Later on as societies became more complex with the growth of technology and as the hold of religion diminished as a control agent, the emphasis shifted from punishment as a preferred sanction for deviance to treatment of illness. Deviance that was considered sin or bad is now considered as sickness.

With increasing success biomedicine started functioning as a control agent.

Review of recent research shows that now many socially unacceptable behaviors have been medicalized and assigned disease terms in the 20th century and even normal human events and common human problems are considered under medical jurisdiction. For instance, alcoholism, drug addiction, hyperactive children, suicide, obesity, mental retardation, crime, violence, child abuse, learning problems, births, aging, menopause and many social deviances are all brought under the umbrella of medicalization. Medicine is all pervasive in our daily life.

At the same time some behaviors previously considered medical problems have become more acceptable and been de-medicalized , e. g., homosexuality and masturbation.

T. Moreira (2006) suggested that the process of medicalisation is insufficient to understand the social aspect of relationship between a state that is considered as medical disorder and health. One needs to also look at the dynamics of the creation, evaluation and use of biomedical knowledge. The need for these dynamics was underlined in her research on relationship between sleep and health. She explored a very common sleep disorder, viz., obstructive sleep apnoea syndrome (OSAS)and shaping of continous positive airway pressure, a very common therapy for obstructive sleep apnoea(CPAP).

She used the method of case study. Two case studies were scrutinized-

1. Historical literature review of emergence and,
2. development of OSAS and CPAP.

Initially sleep apnoea was described as “ Pickwickian syndrome” on the basis of symptoms that led to sleep disturbances. It was believed that sleep apnoea occurs among those who are overweight, lazy and snore loudly causing inconvenience to others. Extreme obesity was associated with severe daytime sleepiness. William Dement et. al. investigated this link by using sleep laboratories.

But by late 1970s, obesity was no more considered the cause of sleep aponea, it was merely seen as a risk factor that may lead to disease. With laboratory observation of sleep it became clear that sleep process was responsible for OSAS and not obesity. There was a shift from “ Pickwickian syndrome” to “ sleep aponea syndrome”. In Pickwickian syndrome, the clinical symptoms like obesity, hypoventilation and plethoric face were

highlighted while in sleep aponea syndrome Apnea/Hypoapnea Index became progressively more acceptable.

The development of CPAP showed how on one hand patients' actively participate in evolving health technology and on the other hand adjust and adapt to devices available according to their own needs and circumstances. In the studies of CPAP users the emphasis shifted on recognizing patients who are likely to discontinue to use these machines rather than blaming the patient for not using it. This led to looking at patient as a natural calculative subject who will do the cost-benefit analysis and decide whether to use health technology or not. This cost-benefit analysis is influenced by many psychological constructs like self identity, self- efficacy, self-confidence and social support, etc. On the basis of these calculations, by non-participation in certain health technologies, patients have created a new area of knowledge and intervention in biomedicine, health psychology, medical sociology and in sociology of science and technology.

Thus medicalization of sleep has redefined the sleep as medically problematic and whole sleep industry has come up in last one decade or so. A person suffering from OSAS is no more stigmatized individual. He is no more powerless passive, dependent on medical personnel. He is a calculating independent person, an active consumer of health technology.

Evolving the design of sleep machines showed that patient groups actively influence making of , evaluation and use of medical knowledge.

Advantages & Disadvantages of Medicalization

1. According to Illich medicalisation has serious adverse impact on the society as the general public is made docile and reliant on the medical profession to help them cope with their life in their society.
2. There is also structural problem as Western medicine’s notion of issues of healing, aging, and dying as medical illnesses. This effectively medicalises human life, rendering individuals and societies less able to deal with these “ natural” processes.
3. Marxists such as Vicente Navarro et. al. (1980) linked medicalization to an oppressive capitalist society. They argued that medicine makes people see health as an individual problem rather than looking at disease as a result of social inequality and poverty. It tends to strip subjects of their social context, so they come to be understood in terms of the prevailing biomedical ideology, resulting in a disregard for over-arching social causes such as unequal distribution of power and resources.
4. Many critics believe that the term medicalization has become much more complex now as pharmaceutical companies have increasingly taken over the role of doctors, putting everyday problems into the domain of professional biomedicine. Direct to consumer advertising further undermines the role of doctors, as patients are encouraged to ask for particular drugs by name, thereby creating a conversation between consumer and drug company.
5. Another problem with medicalization is that it puts the responsibility for the problem on individual causes and the solution to social problems on individual treatment. The psychologizing of social

problems leads away from the analyses of the social structure of culture. For example, the reason for obesity is thought to be the obese person himself rather than the change in life style, socio-economic status of the person, easy availability and convenience of ready to eat junk food, etc.