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ON GOOD AND BAD FORMS OF MEDICALIZATION

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ABSTRACT

The ongoing 'enhancement' debate pits critics of new self-shaping technologies against enthusiasts. One important thread of that debate concerns medicalization, the process whereby 'non-medical' problems become framed as 'medical' problems.

In this paper I consider the charge of medicalization, which critics often level at new forms of technological self-shaping, and explain how that charge can illuminate – and obfuscate. Then, more briefly, I examine the charge of pharmacological Calvinism, which enthusiasts, in their support of technological self-shaping, often level at critics. And I suggest how that charge, too, can illuminate and obfuscate.

Exploring the broad charge of medicalization and the narrower counter charge of pharmacological Calvinism leads me to conclude that, as satisfying as it can be to level one of those charges at our intellectual opponents, and as tempting as it is to lie down and rest with our favorite insight, we need to gather the energy to have a conversation about the difference between good and bad forms of medicalization. Specifically, I suggest that if we consider the 'medicalization of love,' we can see why critics of and enthusiasts about technological self-shaping should want (and in some cases have already begun) to distinguish between good and bad forms of such medicalization.

> *I too believe that humanity will win in the long run; I am only afraid that at the same time the world will have turned into one huge hospital where everyone is everybody else's humane nurse.* Goethe[1]

> *It can be appropriate to use medical means to prevent suffering and enhance well-being even if the source of the problem is not a disease.* Laura Purdy[2]

For the last thirty or forty years, sociologists have used the term *medicalization* to refer to the process by which 'non-medical' (or 'life' or 'human') problems become understood and treated as 'medical' problems.[3] Of course social scientists typically understand themselves to be describing – not evaluating – social processes. Indeed, one of the fathers of medicalization theory, the sociologist Peter Conrad, has stated more than once that the term medicalization is value neutral. In his recent book he writes: 'While medicalization describes a social process, like globalization or secularization, it does not imply that a change is good or bad.'[4]

That assertion notwithstanding, when sociologists use the term medicalization, they have traditionally assumed that the process it names is bad. In this paper, I will suggest that we in bioethics should not make that simplifying assumption, but should instead do the complex work of attempting to distinguish between good and bad forms of medicalization.

[1] Quoted in P. Rieff. 1966. *The Triumph of the Therapeutic: Uses of Faith after Freud.* New York: Harper & Row: 24.

[2] L. Purdy. Medicalization, Medical Necessity, and Feminist Medicine. *Bioethics* 2001; 15(3): 248–261, at 258.

[3] P. Conrad. 2007. *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders.* Baltimore: The Johns Hopkins University Press: 3–4.

[4] P. Conrad, T. Mackie & A. Mehrotra. Estimating the Costs of Medicalization. *Social Science and Medicine* 2010; 70: 1943–1947, at 1943.

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That suggestion might sound radical at first, but it isn't. In fact, into both the sociological and bioethical literatures there has already begun to creep a distinction which does roughly the same work as the distinction I'm getting at with the difference between 'bad' and 'good' forms of medicalization. I am referring to the distinction between 'over-medicalization' (which is assumed to be bad) and 'medicalization' (which is assumed to be not bad).

In an attempt to deflect the criticism that the term medicalization entails but does not acknowledge the assumption that the process is bad, Conrad writes: 'While 'medicalize' literally means 'to make medical,' and the analytical emphasis has been on over-medicalization and its consequences, assumptions of over-medicalization are not a given in the perspective.'[5] That is, in the course of attempting to deflect the charge that the sociological analysis takes the badness of medicalization to be 'a given,' Conrad tacitly distinguishes between *over-medicalization*, which is bad, and *medicalization,* which apparently is not.

One can find the same tacit distinction in the bioethics literature. In their argument for distinguishing between using memory-attenuating drugs to respond to Post Traumatic Stress Disorder (which they approve of) and using the same drugs to achieve non-medical purposes (which they do not approve of), Michael Henry and colleagues write: 'If memory-attenuating drugs prove effective, we argue that the most immediate social concern is the over-medicalization of bad memories and its subsequent exploitation by the pharmaceutical industry.'[6] Like Conrad, Henry et al. tacitly distinguish between medicalization and over-medicalization. They approve of the sort of 'medicalization' that occurred when we applied the PTSD diagnosis to the once-familiar human problem of shell shock, but disapprove of the sort of 'over-medicalization' that a pharmaceutical company might initiate with the creation of a new diagnosis like Bad Memories Syndrome.

I am merely suggesting that we should become explicit about what we're already trying to do: get over the traditional assumption that medicalization is bad *per se*, and try to articulate the difference between good and bad forms of it. In preparation for explicating how such an attempt has actually begun in the context of the debates about using pharmaceuticals to shape our experience of love, I want first to rehearse what I take to be the great insights as well as the blind spots built into the term medicalization.

[5] Conrad, *op. cit.* note 3, p. 5.

[6] M. Henry, J.R. Fishman & S.J. Younger. Propranolol and the Prevention of Post-Traumatic Stress Disorder: Is It Wrong to Erase the 'Sting' of Bad Memories? *Am J Bioeth* 2007; 7(9): 12–20, at p. 13.

I. THE *MEDICALIZATION* CHARGE HAS TRADITIONALLY ILLUMINATED AND OBFUSCATED

What's wrong with medicalization?

First, construing non-medical (or life or human) problems as medical problems, construing normal human variations as pathological, commits a category mistake. Sadness is a problem that human beings experience when, for example, someone they love dies. Shyness can be an unpleasant state that many people experience upon meeting new people. Short stature can occasion unpleasant feelings in some short individuals. And so on. But, the critic of medicalization observes, neither sadness[7] nor shyness[8] nor short stature[9] is a *medical* problem. Sadness is a normal, perhaps even essential part of a full human life. The feelings that can go with being sad or shy or short may be difficult, but they are not symptoms of disease; only disease-mongers suggest otherwise.

To treat human problems as medical problems, according to the critique, is to make a mistake about the nature of the world. Seeing clearly and living well require us to avoid such a mistake. More specifically, living well requires that we learn to let some sorts of problems be. It requires that we learn to affirm, rather than try to erase, variations in our moods, behaviors, and appearances.

In addition to entailing a category mistake, medicalization can have bad consequences. Perhaps the easiest to see is that, insofar as medicalization expands the category of what warrants medical treatment, the cost of medical treatment grows exponentially. While this may be to the advantage of gluttonous purveyors of medical products and services, it makes it ever harder for any government to pay for medical care for all.[10] On top of the astronomical direct costs of such interventions are the indirect costs of their side-effects.

A second bad consequence is that, insofar as the institution of medicine focuses on human beings as *objects* (i.e. as bodies), the medicalization process potentially undermines seeing ourselves as *subjects*; it potentially undermines our 'subjectivity.' When we argue, say, against the medicalization of badness – e.g., against treating criminal behavior as the symptom of a psychiatric disorder – we are arguing against the view of ourselves as objects at the mercy of forces beyond ourselves, and for the view of ourselves as subjects who can choose.

[7] A.V. Horwitz & J.C. Wakefield. 2007. *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder.* Oxford and New York: Oxford University Press.

[8] C. Lane. 2007. *Shyness: How a Normal Behavior Became a Sickness.* New Haven & London: Yale University Press.

[9] S. Cohen & C. Cosgrove. 2009. *Normal at Any Cost: Tall Girls, Short Boys, and the Medial Industry's Quest to Manipulate Height.* New York: Jeremy P. Tarcher/Penguin.

[10] Conrad, Mackie & Mehrotra, *op. cit.* note 4.

Similarly, when, for example, we argue against using medical *means* such as drugs to treat sadness, we are often arguing against the view of ourselves as objects that can be fixed and for the view of ourselves as subjects who can be influenced by reasons.[11] The critic of medicalization can accept that we need both ways of understanding ourselves, but worry that the medical way is crowding out the other. This is at least one thing critics are getting at when they suggest that we should use means like psychotherapy before or instead of using drugs.

A third bad consequence of medicalization is that, insofar as medicine focuses on changing individuals' bodies to reduce suffering, its increasing influence steals attention and resources away from changing the social structures and expectations that can produce such suffering in the first place. The idea is that, for example, rather than changing the bodies of shy people with drugs, we could change our expectations of how people behave in novel situations; again, doing so, would exemplify the virtue of learning to affirm natural variation. Further, changing social expectations would be fairer to individuals, who, instead of changing their bodies to better fit dominant norms, could, again, be affirmed in their norm-challenging variation.[12]

Whether critics argue that we are making a category mistake, or are creating a putative need that no government can afford to fulfill, or are undermining understanding ourselves as subjects, or are obscuring understanding the social sources of suffering, the basic idea is that it is bad when the institution of medicine oversteps its proper limits.

As someone who is by nature-nurture a critic of medicalization, I think that the preceding worries are insightful and important. But I also want to call attention to what the critique can obfuscate. Specifically, I want to call attention to some of the problematic assumptions that the critique inadvertently entails – where by 'problematic' I mean assumptions that contradict or at least are in tension with other assumptions that critics like me tend to embrace.

Problematic assumptions built into the notion of medicalization

First, the idea of medicalization depends upon the notion that medicine has 'proper' goals, which are visible to those with knowledge of the essence of medicine. More specifically, while it's true that *broad* conceptions of the goals of medicine (such as the World Health Organization's)[13] are indeed available, one needs a *narrow* conception of those goals to get traction for the medicalization critique. Without a narrow conception, one can't restrict the range of the targets that medicine 'properly' aims at. Those of us attuned to how institutional goals change over time with the coming and going of more and less savory political interests, however, will be wary of an analysis that assumes knowledge of a given institution's 'proper' or 'essential' or 'real' goals.

Peter Conrad fully anticipates such wariness. Indeed, he begins his recent summary of his thinking on medicalization by saying that he will 'bracket' the question of whether the conditions he says are medicalized are 'real' medical problems.[14] To justify setting aside the question of how he knows what a real medical problem is or what the proper goals of medicine are, he makes a distinction. He says that 'it is the *viability* of the designation rather than the *validity* of the diagnosis that is grist for the sociological mill' (emphasis added).[15] He is asserting that when he uses the term medicalization, he does not mean to assume that he knows the difference between valid (or real) medical diagnoses and invalid (or fake) ones; he means only to assume that the new, expanded conceptions of medical problems are 'viable'.

But that distinction does not so much resolve as reintroduce the original concern about essentialism. How does the sociologist know which 'viable' diagnoses to investigate as examples of medicalization? To pick them she has to assume that she knows the difference between viable diagnoses that are valid and viable diagnoses that are not; otherwise she would have to investigate *all* viable medical diagnoses as instances of medicalization – and that is clearly not what is happening. All of which is to say that, the valid/viable distinction seems to depend on the same assumption – about knowing the difference between real and fake medical conditions – that Conrad recognizes is problematic. The specter of inadvertent essentialism remains.

The medicalization critique's narrow conception of the goals of medicine harbors other problematic assumptions as well. For one thing, it usually if not always entails the dualistic notion that the proper target of medical intervention is the disordered body, as distinct from the troubled mind. One familiar variation on this theme suggests that medicine should deal with disorders of the body, not disorders of the mind; or that it should treat disorders that are 'organic,' not ones that are context-dependent.

For example, in a recent essay Jonah Lehrer recounts the tale of a psychiatrist who was taken aback to notice

[11] C. Freedman. 1998. Aspirin for the Mind? Some Ethical Worries about Psychopharmacology. In *Enhancing Human Traits: Ethical and Social Implications.* E. Parens, ed. Washington, DC: Georgetown University Press.

[12] A. Dreger. 2004. One of Us: Conjoined Twins and the Future of Normal. Cambridge MA: Harvard University Press.

[13] In its constitution, the World Health Organization famously defines health as a 'state of complete, physical, mental, and social well-being'.

[14] Conrad, *op. cit.* note 3, p. 4.

[15] Ibid.

that, in his enthusiasm for prescribing antidepressants, he had failed to distinguish between suffering rooted in his patients' dysfunctional bodies and suffering rooted in their minds or social contexts. The psychiatrist's epiphany came when he asked one of his patients whether her antidepressants were working. She answered, 'Yes, they're working great . . . I feel so much better. But I'm still married to the same alcoholic son of a bitch. It's just now he's tolerable.'[16] Lehrer and the psychiatrist's point of course is that, because the woman's problem was rooted in her relationship with her alcoholic husband rather than in her dysfunctional body, it was a mistake to treat her.

That line of criticism's great virtue is that it can be used to shelter some dimensions of human life from the raging storm of medical intervention. But it is important to beware of the lurking mind-body dualism. In the case Lehrer describes, the alternatives seem to be that the source of the woman's suffering is either her body or her mind (and relationships). If we successfully jettisoned mind-body dualism, however, we would be wary of that disjunction. We might wonder, for example, about the role her embodied mind played in her entering into such a relationship in the first place. Such a question would not aim to blame the victim (!), but to remind us of how staggeringly complex mind-body (-world) interactions are. It would remind us to be on the lookout for an assumption that we would normally reject.

Yet another problem with the critics' narrow conception of the goals of medicine is that it usually entails – whether explicitly or inexplicitly – some notion of *normal* or *species-typical* functioning.[17] The idea is that that we can look out into nature, discern the line between species-typical and atypical functioning (or between behaviors inside and outside of the normal range), and thereby know whether to intervene. If the individual exhibits species-atypical (or ab-normal) functioning, she occupies a disease category and we should intervene, and if her functioning is typical (or normal), she doesn't occupy a disease category and we shouldn't intervene.

It would be lovely if we could look to nature and discern the line between species-atypical and species-typical functioning, between the categories of disease and health. That way it wouldn't be our ethical responsibility to decide, based on our understanding of the facts and our values, whether to intervene. We'd just point to nature.

Alas, one would be hard pressed today to find a natural scientist who studies the etiology and diagnosis of disease and believes that those lines and categories are there for us to discover. Geneticists, neuroscientists, and others increasingly abandon the species-typicality model, which seeks to discover typical functioning, to embrace an *individual-differences* model, which seeks to understand why it is that, within populations, there is almost always *continuous variation* with respect to any trait or cluster of traits.

On the individual differences view, what we call disorders are almost always 'dimensional,' not 'categorical.' As the psychiatric geneticists Ian Craig and Robert Plomin put it:

> Whereas the species typicality model . . . assumes that mental illness is a broken brain, . . . the individual differences model considers variation as normal. . . . Common mental illness is thought to be the quantitative extreme of the normal distribution.[18]

According to the individual-differences model (and the dimensional view that goes with it), there is no value-free, readily visible line between behaviors and traits that really are – and really aren't – disordered.

This is unfortunate in at least two very different ways. First, it means that purveyors of cures have ever more grounds to assert that even if we aren't floridly ill, we're still ill enough to purchase their cure; they can – and do – argue that we are within in the penumbra of illness.[19] Second, it means that the ethical responsibility for deciding whether or not to intervene falls to us and our value-laden interpretations of nature; we can't rely on the hoped-for, value-free guidance from nature.

II. THE *PHARMACOLOGICAL CALVINISM* CHARGE HAS TRADITIONALLY ILLUMINATED AND OBFUSCATED

In principle, the medicalization charge can be used to criticize the use of any means to achieve what is construed to be a non-medical purpose. But in our current context, with the avalanche of ever more pharmaceuticals, the medicalization charge often refers to the use of *pharmacological* means to deal with some normal human problem.

When enthusiasts about self-shaping hear the medicalization charge, they sometimes exasperatedly counter that the critics suffer from 'pharmacological Calvinism.' Gerald Klerman first used that now-famous phrase in the early 1970s, in an article in the *Hastings Center Report.*[20]

[16] J. Lehrer. 2010. Depression's Upside. *New York Times Magazine* 28 February: 42.

[17] For a classic, explicit discussion: N. Daniels. 1986. *Just Health Care*. Cambridge: Cambridge University Press.

[18] J.I. Craig & R. Plomin. Quantitative Trait Loci for IQ and Other Complex Traits: Single Nucleotide Polymorphism Genotyping Using Pooled DNA and Microarrays. *Genes, Brain, and Behavior* 2006; 5 (Suppl. 1): 32–37, at p. 33.

[19] M. Loe. 2004. *The Rise of Viagra: How the Little Blue Pill Changed Sex in America*. New York: New York University Press.

[20] G.L. Klerman. Psychotropic Hedonism vs. Pharmacological Calvinism. *Hastings Cent Rep* 1972; 2 (4): 1–3.

According to Klerman, pharmacological Calvinists think that 'if a drug makes you feel good, it not only represents a secondary form of salvation but somehow it is morally wrong and the user is likely to suffer retribution with either dependence, liver damage, . . . , or some other form of medical-theological damnation.' Klerman continues, 'Implicit in the theory of therapeutic change is the philosophy of personal growth, basically a secular view of salvation through good works.'[21]

As Klerman was a psychiatrist, not a theologian, we can set aside his unconventional understanding of Calvinism and try to understand the insight at work in his charge. A less snarky version might read: 'If pharmacological and psychotherapeutic means can both achieve the same end – improving how one experiences herself and the world – then it is irrational and perhaps inhumane to prefer the more strenuous and expensive means. It's irrational not to take a shortcut when improving human well-being is the destination. We should be slower to imagine that suffering leads to growth and understanding, and quicker to remember that sometimes it just crushes human souls.'

Even if the chances of finding a 'pharmacological Calvinist' in the USA today are about as good as spotting a bald eagle in Manhattan, Klerman was surely right to observe that we come from long and particular traditions (originating in both Jerusalem and Athens), which have taught that with suffering comes understanding. Those traditions have valorized the suffering that goes with large and small normal human problems.[22] Insofar as those traditions celebrated suffering for which there were no medical remedies, Klerman must be right that at least to some extent those traditions made a virtue of necessity.

But he must be wrong to the extent that his charge invites us to ignore the respect in which suffering *can* be a crucial element in a good human life. To take but one example, which I mentioned above: even the staunchest self-shaping enthusiasts acknowledge the respect in which suffering from the loss of someone we love is 'proper' – and as such should be endured rather than erased. (Yes, I did suggest above that the notion of 'the proper' can obfuscate and here I am suggesting that it can illuminate.)

Moreover, the charge of pharmacological Calvinism must be wrong to the extent that it ignores how the *means* we use to reduce the suffering associated with normal problems can matter morally. As critics of medicalization argue, using medical means to solve normal human problems can lure us into thinking that the individual rather than her social context is the source of the problem. It can lure us into attending only to the respect in which we are objects – and ultimately to forgetting that we are also subjects, who can remedy some problems by giving and taking reasons to change our minds and contexts.

Klerman's charge can also obfuscate the fact that different means can emphasize different values in an even more obvious sense. Insofar as means like medications can be cheaper or work more quickly than, say, means like words, they can emphasize the value of *efficiency*. Insofar as means like words require the giving and taking of reasons between persons, they can emphasize the value of *engagement*.

So, like the medicalization charge, the 'pharmacological Calvinism' charge can both help us to think and give us an excuse to stop thinking. If that's right, we are saddled with a daunting ethical responsibility. By 'we' I mean those who think it is important to respond to the suffering of individuals *and* that it is important to attend to the social roots of that suffering; those who think it is important to consider ourselves as subjects *and* that we should be grateful for the ways in which considering ourselves as objects can help us to diminish human suffering; and those who worry that medicalization can be bad *and* believe that choosing for or against 'medicalization' full stop could be lazy or unhelpful. By 'ethical responsibility' I refer to the responsibility to attempt to distinguish between good and bad forms of medicalization.

III. TOWARD A CONVERSATION ABOUT THE DIFFERENCE BETWEEN GOOD AND BAD FORMS OF MEDICALIZATION

To start, it helps to remember the respect in which we already do embrace some forms of medicalization. When for example Dostoyevsky wrote *The Idiot*, the cluster of traits that today we call epilepsy was called a divine gift. In the beginning of the 20th century, that cluster of traits was construed as a 'psychological' disorder, and today we are confident that 'it' is a proper medical disorder. None of us criticizes the process whereby that particular constellation of traits was transformed from a divine gift into a medical problem. Nor does any of us criticize the process whereby what today we call Alzheimer's disease went from being interpreted as the moral problem of 'senility' to being interpreted as a medical problem.

One could counter that these aren't examples of 'good' medicalization. Rather, they are only examples of us overcoming past mistakes: calling epilepsy a disease instead of a divine gift is just an example of aligning our everyday practice with our deeper scientific or medical knowledge. Mistaking epilepsy for a divine gift, goes this argument, is no more interesting than mistaking whales for fish.

[21] Ibid: 3.

[22] Joshua Wolf Shenk's account of how Abraham Lincoln's 'melancholia' was not just a huge burden, but also a crucial ingredient in his great life, is but one recent, very fine example of that tradition; see J.W. Shenk. 2005. *Lincoln's Melancholy: How Depression Challenged a President and Fueled His Greatness.* Boston: Houghton Mifflin. For an attempt to extirpate that tradition, see P Kramer. 2005. *Against Depression.* New York: Viking.

Fair enough. But this brings us to straightforward, harder-to-dismiss examples to support my suggestion that we should be skeptical about assuming that medicalization is bad, full stop.

Many feminists and fellow travelers have in the past, with good reason, lamented the medicalization of everything from childbirth, to menstruation, to menopause.[23] More recently, the institution of medicine has brought within its purview 'labia-plasty,' which its practitioners say can be used to treat 'emotional problems such as embarrassment, anxiety, and loss of self-esteem'[24] related to the shape of one's labia minora. The profound, amply-supported concern is that, by bringing ever more normal features of women's bodies and lives within the purview of medicine, disease mongers diminish women's power to control their own bodies and, more generally, diminish their ability to flourish.

While there may be no better arena than what gets called 'women's health' to witness dis-empowering forms of medicalization, there may also be no better place to see empowering forms. As feminist philosopher Laura Purdy has argued in this journal[25] – and others have argued elsewhere[26] – a blanket condemnation of medicalizing 'normal facets' of women's (and men's) lives fails to acknowledge the respect in which women (and men) use medical technologies to gain control over their lives to promote their own flourishing.[27]

Consider for example the normal human capacity of producing eggs (or sperm), or the normal capacity of bringing a fertilized egg to term. Given that those capacities can't be construed as symptoms of disease, and given that becoming pregnant when one doesn't want to is a perennial human problem, we must grant that using medical technologies to control those capacities (from birth control pills, to vasectomies, to IUDs) are forms of medicalization – forms of medicalization that seem good to many of us.

Even many of us who are in general deeply, wholeheartedly critical of the idea that more control is always better, embrace technologies that allow women to determine if and when they will become pregnant. We embrace those technologies not only because we believe that women have a right to self-determination, but because we know that women who cannot control if and when they become pregnant are at significantly increased risk of living (along with their children) lives blighted by poverty. For this observer, fertility control counts as a good form of medicalization.

Of course, 'many of us' isn't all of us. Who, though, objects to the process whereby what once was considered chronic pain associated with normal aging came to receive labels like Complex Regional Pain Syndrome (CRPS)?[28] Before we could do anything to treat such pain, we construed it as a normal, if difficult part of the aging process. But once it's technically feasible for healthcare professionals to reduce such pain, the door swings wide open to new diagnostic labels and 'treatments'. What was once a problem of everyday living becomes a medical problem. It is a classic example of the medicalization process – but, I am suggesting, an example of 'good' medicalization.

IV. THE MEDICALIZATION OF LOVE

In the conclusion of a forthcoming essay, 'Bioethics and Medicalization,' the sociologist John Evans, writes:

> Most scholars of medicalization seem to have reached the normative conclusion that they do not want to live in a world where increasing swaths of human experience are under the logic of medicine. There are, or should be, experiences that use an older logic, which are under the jurisdiction of another profession or under no jurisdiction at all. *We can all fear the medicalization of love* (emphasis added).[29]

At work in Evans's claim, is the at-first seemingly obvious assumption that medicalizing love is bad, full stop. But I want to suggest that even in the case of love, we need to try to distinguish between good and bad forms of medicalization. Indeed, I want to suggest that in the bioethics literature we can already begin to glimpse progress toward making such a distinction.

[23] K. Morgan. 1998. Contested Bodies, Contested Knowledges: Women, Health and the Politics of Medicalization. In *Agency, Autonomy, and Politics in Women's Health*, Susan Sherwin, ed. Philadelphia, PA: Temple University Press.

[24] J.R. Miklos & R.D. Moore. Labiaplasty of the Labia Minora: Patients' Indications for Pursuing Surgery. *J Sex Med.* 2008;5: 1492–1495.

[25] L. Purdy. Medicalization, Medical Necessity, and Feminist Medicine. *Bioethics* 2001;15(3): 248–261.

[26] K. Davis. 1995. *Reshaping the Female Body: The Dilemma of Cosmetic Surgery.* New York: Routledge; M. Lock. The Tempering of Medical Anthropology: Troubling Natural Categories. *Medical Anthropology Quarterly* 2001; 15(4): 478–492; J.Z. Sadler, F. Jotterand, S.C. Lee & S. Inrig. Can Medicalization Be Good? Situating Medicalization within Bioethics. *Theoretical Medicine and Bioethics.* 2009; 30(6): 411–425.

[27] For a fascinating variation on this theme, see E. Feder. Imperatives of Normality: From 'Intersex' to 'Disorders of Sex Development.' *GLQ* 2009; 15(2): 225–247. In discussing people who have atypical-appearing genitalia due to a disorder of sex development, Feder argues that Foucault's understanding of the power of 'normalization' helps us to 'make sense of the history of medicalization and its pernicious effects' – *and also allows us to see* the 'positive possibilities' of going from viewing atypical genitalia as identity-constituting to viewing them as symptoms of a medical condition.

[28] I am grateful to an anonymous reviewer for this example.

[29] J. Evans. Bioethics and Medicalization. (Forthcoming).

Even mortal academic foes can sometimes agree on the difference between good and bad forms of medicalization

In its characteristically heterocentric and fuddy-duddy tone, in *Beyond Therapy* the President's Council on Bioethics offers a scenario that makes a deeply important point. They invite us to imagine a young man at a party who is under the influence of Ecstasy and begins a conversation with a woman he has never met before. He tells her that he loves her and wants to marry her. The Council invites us to imagine that the man means what he says 'insofar as the feeling he now has is indistinguishable from what he might one day feel when he truly falls in love with a woman.'[30] Then the Council asks, 'Should the fact that this man's feelings are produced by the drug, rather than inspired by the woman, matter?'

The Council argues that it should matter to the woman and to the man. It should matter to her because she wants to be seen as she truly is, not as the drug makes her seem. She wants recognition. And it should matter to him, too, insofar as he should want his love to be real. As the Council puts it, 'The young man's drug induced 'love' is not just incomplete – an emotion unconnected with knowledge of and care for the beloved. It is also unfounded, not based on anything – not even visible beauty – from which such emotions normally grow.'

Even we post postmodernists are here thrown back on some version of the distinction between the true and false, authentic and inauthentic. Even we have to accept the inescapability of such a distinction in the context of thinking about the sort of love we want for ourselves and for those we love. We want our feelings of love to grow out of knowledge of and care for the other. We want them to grow out of engaging in activities with the person we love. We want the other's love for us to be chosen freely. We, even we post postmodernists, don't want to settle for the feelings that grow out of a drug alone.

No one familiar with the bioethics literature will be surprised to find this sort of argument in a report by the President's Council, which is known both for its critique of self-shaping in general and medicalization in particular. It may be more surprising, however, to find a similar argument being made by enthusiasts about technological self-shaping.

In a recent paper, Julian Savulescu and Anders Sandberg define a good marital relationship as 'one which both parties desire and which gives each pleasure, and allows or facilitates each to lead lives which are objectively valuable.'[31] To advance their argument, they make a distinction, which reveals an important value commitment they share with their academic foes, The President's Council. Savulescu and Sandberg distinguish between using a drug to *maintain* a loving attachment and using a drug to *create* such an attachment.

Specifically, they endorse using technology to *maintain* a relationship that is founded on shared perceptions of the goodness of the other, and the shared experiences that grow out of such perceptions, but they reject using technology to *create* the feelings normally associated with such perceptions and experiences. As the President's Council might put it, we don't want the illusion of love, we want the real thing. To make their point, Savulescu and Sandberg even use the language of authenticity, which is as unusual for them as it is usual for the Council. They write, 'The use of drugs to instill a new love is more likely to create inauthentic love, since the causal reasons for the love may lie in the drug . . . , rather than the particular person loved.'

So at least we can say that, insofar as being without love is a normal, human, non-medical problem, and insofar as both sides would oppose using a technology to remedy that problem by *creating* a love out of whole cloth (i.e. in the absence of the feelings and experiences normally associated with love), it is fair to say that both sides agree that using a technology to create love out of whole cloth would be a bad form of medicalization. The problem is normal but the medical-technological solution is bad.

But can both sides agree on a good form of medicalization? Well, Savulescu and Sandberg say that marriage counseling is a perfectly fine way to *maintain* a love relationship. The President's Council doesn't speak directly to this issue, but I see no evidence that they would disagree. Insofar as relationship difficulties are a normal human problem, and insofar as marriage counseling is sometimes done by people with medical degrees, it seems fair to say that both sides could in principle agree that relationship counseling to maintain a marriage relationship could be a good form of medicalization.

While both sides might agree that using words (as in counseling) to treat relationship problems is a good form of medicalization – or at least is not a form of 'over-medicalization' – things might become more contested if someone proposed using drugs to remedy those problems. For example, would both sides agree that it is a good form of medicalization for marriage counselors to use Ecstasy to facilitate marriage counseling? (This is not hypothetical; Ecstasy has been used for this purpose.)[32]

[30] President's Council on Bioethics. 2003. *Beyond Therapy: Bioetechnology and the Pursuit of Happiness* New York, NY, Regan Books: 253. This is of course a variation on Robert Nozick's famous 'experience machine' thought experiment in *Anarchy, State, and Utopia*.

[31] J. Savulescu & A. Sandberg. Neuroenhancement of Love and Marriage: The Chemicals between Us. *Neuroethics* 2008; 1: 33–44.

[32] S. Braun. 2001. Seeking Insight by Prescription. *Cerebrum.* 1 April. Available at: http://www.dana.org/news/cerebrum/detail.aspx?id=3046 [accessed 20 Jan 2011].

We can imagine that whereas the President's Council might object, Savulescu and Sandberg would not.

Indeed, even if Savulescu and Sandberg would oppose the *creation* of relationships with drugs, their conception of the appropriate use of drugs to *maintain* a relationship is far more expansive than the Council's. Indeed, they invite their readers to imagine a woman who takes herself to be in a good and loving relationship with a man who happens to be promiscuous, and then invite us to accept that, in an effort to maintain her relationship, this woman might autonomously choose to take a drug that allowed her to tolerate her husband's promiscuity.

It strikes me that, for Savulescu and Sandberg to be consistent, they should reject the promiscuity-toleration pill on the same grounds that they rejected a pill that created the feelings of love out of whole cloth. In both cases, rather than facilitating engagement with the world as it really is, the pill distances the relevant parties from the world as it is. Again, however, their published article indicates that they *could* condone a drug that made the promiscuity of one partner tolerable for the other.

But even if Savulescu and Sandberg agreed that, to be consistent, they should reject the promiscuity-toleration drug, I am surely not suggesting that they and the President's Council agree on precisely how to articulate the difference between good and bad forms of medicalization – or between 'medicalization' and 'over-medicalization.' I am only suggesting that self-shaping critics and self-shaping enthusiasts do agree – at least implicitly – that we should attempt to articulate that difference. Insofar as some forms of medicalization can maintain or facilitate, as opposed to create or thwart, human relationships and experience, both sides – no matter how different their tones – need some version of that distinction.

CODA

Early on in this paper, I mentioned Jonah Lehrer's example of the unhappy woman who was married to an alcoholic man. Following Lehrer, I suggested that construing her normal human unhappiness as depression would be a distressingly bad form of medicalization. No matter how much the medication might attenuate her suffering, that could not justify her becoming complicit in cutting herself off from an important feature of her life as it truly was.

In that case, however, 'the alcoholic husband' was a sort of prop (not unlike 'the promiscuous husband' was for Savulescu and Sandberg). Lehrer and I were using the alcoholic husband to try to understand what we thought of the woman using an antidepressant to manage her unhappiness. But now we can ask, What should our attitude be toward her husband? Would it be bad to construe his alcoholism – and his accompanying unhappiness – as a medical disorder? Would it be bad to medicalize his bad behavior?

I don't think it would. Above I rehearsed some of the ever-present, very real social and philosophical dangers associated with medicalizing such behavior. I think, however, that if we remain vigilant about the ever-present dangers associated with the process of medicalization, and if the medical model of alcoholism can help someone to remedy the common human problem of excessive drinking, then medicalizing the alcoholic husband's bad behavior might be good. To the extent that construing his bad behavior as a 'medical' problem can help him to take responsibility for his life and to start engaging in the sorts of meaningful relationships and activities that human beings seem to need and want, this seems to be a good form of medicalization

This may make me a prime exhibit for (the sociologist) John Evans's case that 'bioethics' has itself become an 'engine' of medicalization.[33] And perhaps beginning to say out loud that some medicalization can be good puts us at still greater risk of creating exactly what Goethe feared: a world turned into one huge hospital, where everyone is everybody else's humane nurse. I don't dismiss or minimize either of those concerns. On the contrary, they trouble me deeply.

But if we are committed to 'ambiguity and complexity' (as Evans says sociologists are, and I would say we all should be), if we are committed to helping flesh-and-blood human beings to engage in meaningful activities and relationships, then we might have to try to distinguish between good and bad forms of medicalization. That would take time and energy, and would delay the rest we all desire, but it might also be what we owe each other if flourishing for all is what we're really after.

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[33] Evans, *op. cit*. note 29.