

The Palgrave Handbook of Gender and Healthcare

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6 Gender and the Medicalization of Healthcare

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Introduction

Medicalization is a key concept of modernity, ubiquitously used in the social and medical sciences since the 1970s. We begin by adopting what sociologist Peter Conrad calls its essential meaning: '*defining a problem in medical terms, usually as an illness or disorder, or using a medical intervention to treat it*' (Conrad, 2005: 3, emphasis in the original). In this large and growing field, scholars generally agree that medicalization was a critical – if not fundamental – transformation of the 20th century. As we will show in this chapter, scholars disagree about its definitions, its connection with the dynamics and conceptual apparatuses of modernity and a global economy, and its cultural situatedness.

There are dangers of writing critically about medicalization. One of the dangers, resulting from its conceptual origins, is to assume the binaries of men/women, femininity/masculinity and sex/gender. Another is to get stuck in a Eurocentric frame and to focus empirically on studies of its processes in North America, the UK and 'the west' more generally. This limits the development of medicalization theory. Just as medical anthropologists are increasingly examining US/western biomedicine as sites of ethnographic and cultural analysis, so should sociologists turn their gaze to more international and global concerns.

Although it is a gender-neutral term, the concept of medicalization historically has been linked to women. Most of the early work in sociology was about the medicalization of women's bodies; focused on the process by which conditions were defined and treated from a 'top down' perspective; and gave attention to Anglo-American settings. Recent feminist and gender scholarship has begun to re-imagine what medicalization is, to consider how medicalization affects men and women, and how gendered medicalization is more complicated than dichotomous views allow (Clarke et al., 2003). These reconsiderations reflect developments in sexuality scholarship and the turn in social science research to the study of global processes.

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This chapter incorporates specific examples in gender and sexuality studies to reflect upon the political and theoretical significance of medicalization in people's lives and the implications for global healthcare policy. We ask how men's bodies are medicalized and how this process is similar to or different from women's experience. When sexuality enters into the debate, how do we think about transgendered people and their bodies? How has categorical thinking about gender and sex limited understandings of gendered medicalization?

Much of the early research was guided by theories of professional dominance and/or social construction. Current scholarship has refocused our analytic gaze from the power and authority of the medical profession to consider the active participation of individual patients/consumers/users individually and collectively (Figert, 2010). Informed by this refocus we ask how medicalization occurs within the increasingly complex healthcare system, erosion of physician control and professional dominance, and the expansion of expert patients. What happens when medicalization is actively sought instead of challenged? How have patterns of direct-to-consumer advertising and risk trafficking in some economies (notably the USA and New Zealand), and the global circulation of pharmaceuticals and biomedicine, influenced policy and practice? Pharmaceuticalization, biomedicalization and geneticization are concepts developed to describe and explain these complexities.

Tracing medicalization

The process of medicalization has a long and varied history. Historians and anthropologists document its beginnings in 17th-century western modernization and the application of scientific knowledge (Lock, 2004). The location of medicalization within large-scale social processes, such as modernization, the rise of a positivistic framework for understanding social problems, public health programmes of the modern state, and the emergence of science and the professions, is echoed throughout the historical and anthropological literature. To simplify, medicalization is a process associated with modernity.

The term medicalization itself has its roots in mid- to later 20th-century scholarship in the social sciences and humanities. The early sociological work of the 1970s focused upon the technically competent power and authority of physicians in modern society to define and treat individual patients. At the macro-level, it was pointed out that physicians and their organizational representatives have the authority and professional power in modern society to define and control what is formally recognized as a disorder, sickness or deviance; sociological analyses traced the medicalization process from the top down (Conrad and Schneider, 1980; Zola, 1972). The concept of control was prominent, used to explain consumers' demand (to control and improve

upon their physical bodies) as well as medical imperialism (to control deviance through surveillance and the rational application of science to everyday life) and the turn to treatment as opposed to incarceration or punishment for deviance and mental illness (Lock, 2004).

While successful in documenting the process of medicalization in modern medicine, the focus on deviance (from badness to sickness) and on authority and professional control resulted in gender being relatively absent from this early sociological work (Plechner, 2000). Supported by a burgeoning body of feminist scholarship on women's bodies and the concurrent rise of the Women's Health Movements in the USA and western societies, historians, anthropologists and sociologists focused upon the connections between women's bodies and the greater control/medicalization of them by a predominantly male medical profession and a gendered scientific knowledge base. This research initially focused upon gender-specific processes such as childbirth and women's reproductive cycles (Leavitt, 1984; McCrea, 1983).

Most of the sociological scholarship in the 1980s and 1990s continued to take more of a social constructionist approach to medicalization in its examination of the construction of diagnostic categories, professional process and social control of behaviours. Articles by Riessman (1983) and Bell (1987) are noticeable exceptions to the early medical sociology work on medicalization and were important in challenging the idea that medicalization is entirely a top-down process and that women were passive recipients (as opposed to active proponents) of medicalization by a primarily male medical profession. However, feminist work in medical sociology in this period continued to emphasize the unique ways in which women's bodies were more susceptible to medicalization than men's bodies through processes such as childbirth, premenstrual syndrome (PMS) and menopause (Figert, 1996; Plechner, 2000). The literature since the late 1990s has taken a more expansive view of sex/gender to include men's bodies and intersex/transbodies and of recent feminist thought – in particular intersectionality and attention to international, global and transnational processes. Thus Conrad writes:

Men and masculinity have often been omitted from analyses of medicalization, in part because of the belief that men are not as vulnerable to medical surveillance and control (e.g., monitoring and intervention for medical conditions) as women. But ... such a belief is no longer tenable. (2007: 43–4)

In Conrad's work, the absence of a specific mention about men's bodies does not mean that men were absent from the analysis. Men and male bodies were the focus of a few early medicalization studies in sociology, notably of Conrad's

own research about hyperactivity and alcoholism, but these studies did not use gender as a lens for understanding (Conrad and Schneider, 2000).

Masculinities and medicalization

As the above statement by Conrad (2007) points out, medicalization studies are now turning their analysis to the male body in order to remedy the equation of gender with women in sociological work. Thus scholars no longer ask *whether* men's bodies are medicalized but how, why and under what circumstances (Riska, 2003). Just as earlier studies of women expanded their focus beyond the reproductive realm, studies of men and medicalization have moved away from the initial focus upon the definition and control over sexuality to address how boys and men are medicalized through attention deficit hyperactivity disorder (ADHD) pharmaceuticals, sexual dysfunction and post-traumatic stress disorder (PTSD) treatments, and the development of the diagnostic category of 'andropause' to apply to ageing male bodies (Rosenfeld and Faircloth, 2006). Scholarly attention to the medicalization of men's sexuality continues, but the focus is less on the definitions and professional control of homosexuality than on the medicalization of heterosexual male sexuality, specifically, pharmaceutical interventions for male erections (Loe, 2004). Annandale and Riska argue that:

[a]lthough the empowerment of consumers and the increased importance of the pharmaceutical industry – the so-called medical industrial complex – have been identified as independent actors in the construction of disease categories in general and medicalization in particular ... the gendered implications of this development have been insufficiently realized to date. (2009: 127)

So where to go with this burgeoning field? All of these works on both men and women still assume sex and gender as categories of modernity. That is, studies distinguish sex from gender; they take for granted the biological category of recognized (and fixed) sex differences and the socially constructed categories of those we call men and women or homosexual and heterosexual. As Epstein points out:

In biomedicine as in our culture generally, sex is almost always treated as if it were a simple dichotomous variable. The presumptions are that one is either male or female and that the correct designation is not hard to determine – it can, in effect, be 'read off' the body. But nature knows no absolute distinctions. There is no unambiguous dividing line between the two sexes, and every criterion of differentiation that might be invoked, from genitalia to

hormones to chromosomes, fails to perform a strict demarcating function. (2007: 253)

Early studies in the field of sexuality unpacked the meanings of sex, sexuality and sexual identity and traced the social construction of the categories of homosexuality and heterosexuality. The contribution of these studies to understanding medicalization and masculinity is that they demonstrate the social construction of sexuality, sexual identity and homosexuality and begin to unpack the binaries of heterosexuality/homosexuality and man/woman.

Sexualities and medicalization

It is important to understand how and why men's bodies are also medicalized, but this area of scholarship does not necessarily problematize the sex of the human body. The work in the field of sexuality studies and the history of the medicalization of homosexuality which treats sex and the human body as problematic is foundational to our understanding of trans- and intersex today (Foucault, 1978).

Whereas homosexual behaviours are known to exist in the historical record and in all societies, and the category of homosexual was created and medicalized from the 19th century, transsexuals did not appear or were conflated with homosexuals before the 20th century. As Anne Fausto-Sterling (2000) argues, the 'modern' transsexual could not exist until the availability of hormones and surgery for changing bodies, and these technologies were developed and controlled by medicine. Before the availability of hormones and surgery for changing their bodies, women could pass as men (and vice versa) with clothing, appearance and performance. After the technologies were developed the possibility of 'transsexuals' emerged, but only by gaining access to these technologies. Access was secured when:

... transsexuals convinced their doctors that they had become the most stereo-typical members of their sex-to-be. Only then would physicians agree to create a medical category that transsexuals could apply in order to obtain surgical treatment. (Fausto-Sterling, 2000: 253).

Much like the early literature on women and medicalization, sexuality scholars are quick to point out that trans people were not 'medical dupes' (Rubin, 2006). Transsexuals were dependent on their medical care providers, but their use of the conceptual and material apparatus exemplifies how medicalization became a strategy for those wishing to become transsexuals (Rubin, 2006).

Harry Benjamin introduced the medical category of transsexual in the 1950s to advocate for and to treat people who wanted to permanently change their

physical bodies into those of a different gender. Today 'gender identity disorder' is found in the latest version of the official diagnostic manual of the American Psychiatric Association (APA, 2000). A new generation of trans activists and mental health practitioners points out harmful effects of the medicalized (psychiatric) 'disorder'. Samons writes:

In its current diagnostic form, only a small minority of transgender people benefit from the mental health diagnosis of gender identity disorder. Only a very few have [health] insurance that will pay for any kind of treatment [...] It is a dubious benefit that only a few receive but for which the entire population of transgender people pays the price: the social stigma that results from this labeling of transgender as a mental illness through the existence and use of this diagnosis. (Samons, 2009: xxvi)

To put it in terms of medicalization and gender, many transgender people are actively choosing not to pathologize or medicalize their bodies at the same time that they are actively challenging western and modern concepts of what it means to connect bodies with (sexual and gender) identities. 'Agnes' is one of the more famous cases of trans identity that was documented by the sociologist Harold Garfinkel in the 1960s. As told by Garfinkel (2006[1967]: 58), Agnes presented herself to the Gender Identity Clinic in Los Angeles as someone who was 'a girl' born in a male body that had 'spontaneously begun to feminize at puberty'. Agnes was diagnosed by the doctors at the clinic as having a rare intersexual condition, 'testicular feminization syndrome'. As a result of this diagnosis, Agnes was *allowed* to have a sex reassignment. It was later revealed that Agnes had deliberately lied to her doctors and had taken feminizing hormones before coming to the clinic in order to get past the diagnoses required for the operation (Garfinkel, 2006 [1967]).

While Agnes lied about her body, there are babies born every year with either ambiguous genitalia or where their genitalia are not consistent with their sex chromosomes. Estimates vary widely, but forms of intersexuality have always existed in the written human record (see Fausto-Sterling, 2000). Trans activists challenge the medical and scientific concept of sex and gender binarism, but as Preves points out, sexual surgery is not simply a practice resulting from medical imperialism: 'People who are sexually ambiguous and their families (may) also desire some semblance of normalcy in relation to social expectations of sex and gender' and seek sexual surgery to achieve 'gender binarism', and adopt medical language and categories to make sense of and talk about their experiences (Preves, 2003: 39). This acceptance of medicalized sexuality can make it difficult for intersex individuals 'to question medical opinion or authority, or to seek alternative care' (Preves, 2003: 45).

Expanding the medicalization frame: pharmaceuticalization, biomedicalization and geneticization

Today, scholars are questioning the usefulness of 'medicalization' as a sufficient framework 'in an age dominated by complex and often contradictory interactions between medicine, pharmaceutical companies, and culture at large' (Metzl and Herzig, 2007: 697). Physician power and authority (so important to early theories of medicalization) is changing in the west and indeed waning as a result of healthcare reforms and direct-to-consumer advertising of pharmaceuticals (in the USA and New Zealand) (Rose, 2007). Scholars are demonstrating the differential impact of biomedicalization and pharmaceuticalization across the globe such as found in demands for safe and cost-effective drug treatments for tuberculosis and HIV/AIDS (Petryna et al., 2006). To put it bluntly,

some people are more medically made up than others – women more than men, the wealthy differently from the poor, children more than adults, and ... differently in different countries and regions of the world. (Rose, 2007: 700)

Whereas some populations in some areas of the world are (over)medicalized, other populations in other parts of the world are undermedicalized, and medicalization scholarship suffers from insufficient attention to these differences and their consequences for global health and healthcare. During their travels through the disciplines and among different sociological cultures, scholars have expanded the definition of medicalization and introduced new terms to capture its dynamics in more subtle and nuanced ways (Clarke et al., 2010). Notable among these terms are pharmaceuticalization (Biehl, 2004), biomedicalization (Clarke et al., 2003) and geneticization (Lippman, 1991), which overlap with and provide an analytical focus to particular strands in medicalization.

Pharmaceuticalization

Williams and colleagues have defined pharmaceuticalization thus:

[it] refers to the transformation of human conditions, capacities or capabilities into pharmaceutical matters of treatment or enhancement. As such it overlaps with but extends far beyond the realms of the medical or the medicalised, and serves further to blur the boundaries between treatment and enhancement. (Williams et al., 2008: 850)

Pharmaceuticalization maps on to global patterns of wealth and poverty, power and inequality and extends the concept of medicalization beyond the influence of the medical profession on a person's health or body to include dynamics among states, NGOs and pharmaceutical companies (Busfield, 2006;

Petryna et al., 2006). Attention to the global dynamics of pharmaceuticals is not new, although the dynamics have been transformed in the 50 years since feminist scholars and activists in Women's Health Movements looked critically at the development of the birth control pill and other reproductive technologies (Boston Women's Health Book Collective, 1973; Hartmann, 1987; Roberts, 1997). A recent study of the emergence and contested use of the human papillomavirus (HPV) vaccine for cervical cancer illustrates how the new pharmaceuticalization frame can be applied to understanding the permeation of sexual and reproductive technologies 'with meanings of sex/gender' and their role in the politics of gender and sexuality in social relations (Casper and Carpenter, 2008: 886). In richer countries, pharmaceuticalization combines

the biological effect of a chemical on human tissue, the legitimacy of a condition as a disease, the willingness of consumers to adopt the technology as a 'solution' to a problem in their lives, and the corporate interests of drug companies. Together, these factors [transform] aspects of daily life into disease categories alongside the pharmaceutical agents that 'treat' them. (Fox and Ward, 2008: 865)

In these settings, pharmaceutical companies are either highlighting daily life choices, such as sleeping through the night, or publicizing new conditions and illnesses to gain more customers or consumers of their products (Fox and Ward, 2008). For example, the HPV vaccine is being widely marketed to girls and young women (but not boys or men) in the USA and UK, although most (80–85 per cent) of the annual deaths from cervical cancer are in developing countries (Casper and Carpenter, 2008). Direct-to-consumer advertising (DTCA) reflects global inequalities and contributes to medicalization in many ways. Conrad and Leiter state:

Direct-to-consumer advertising for prescription medications has fuelled the medicalization that analysts noted as increasing in Western societies in the 1980s ... DTCA has become a major source of expanding medical markets and public engagement with medical solutions for life's conditions and problems. (2008: 829)

In addition, DTCA has 'changed the ways physicians and patients speak and listen to each other' (Metzl, 2007: 704). DTCA has also amplified, and in some cases changed, cultural expectations about illness and health, medication prescription and use and, in some ways, normalized the medicalization of the gendered body. Currently, television and radio broadcast advertising of prescription drugs or pharmaceuticals directly to consumers is permitted only in the USA and New Zealand. It is prohibited in the UK and most developed countries.

The globalization of pharmaceutical development has also produced new subjectivities through medicalization. The first is the creation of a need for pharmaceutically naïve subject populations to sustain clinical research and development and the expansions of markets (Petryna et al., 2006). This in turn opens the possibility for individuals and communities to gain access to resources and power and opportunities for citizenship. Other new subjectivities produced through pharmaceuticalization are 'pharmaceutical citizenship' or 'therapeutic citizenship', which can be tools for gaining access to resources and power (Biehl, 2004; Nguyen, 2005).

AIDS policy in Brazil illustrates how pharmaceutical citizenship through the medicalization of HIV/AIDS can be a new democratic tool for individuals, activist groups and states (Biehl, 2004). The Brazilian government joined with the World Bank in 1992 to create a National AIDS Program and by 1996 had begun to provide free antiretroviral drugs to all registered AIDS cases in the country. People with HIV/AIDS who were previously marginalized (noncitizens), claimed 'a new identity around their politicized biology, with the support of international and national, public and private funds' and through their social and biomedical inclusion became 'biomedical citizens' (Biehl, 2004: 122, 123). More importantly, AIDS activists successfully forced the Brazilian government to allow compulsory licensing of patented drugs during a declared public health crisis. In this respect, this therapeutic citizenship comes to represent a biomedicalized form of the state (Nguyen, 2005). Biological notions of citizenship – such as being HIV-positive – are used to ascribe an essentialized identity such as sex or race (Nguyen, 2005). An important effect of selective forms of biomedical citizenship such as the one in Brazil is that they systematically make some people visible and others invisible: 'bureaucratic procedures, informational difficulties, sheer medical neglect and moral contempt, and unresolved disputes over diagnostic criteria' all contribute to turning some people into 'absent things' (Biehl, 2004: 119).

Making visible these macro-processes and their gendered dimensions is key to disentangling how pharmaceuticalization and medicalization are connected, as well as to understanding how they can contribute to the creation of new democratic tools for individuals, activist groups and states and to new possibilities for entering into the grip of (medical) power. Because pharmaceuticalization has occurred so recently, we are just beginning to see how medicalization might work differently (or similarly) for global pharmaceuticalization processes and what the gender implications of this are.

Biomedicalization

Gender is inherently built into the framework of biomedicalization theory. The era of biomedicalization emerged in the mid-1980s along with changes in

high-tech biomedical interventions designed not only for treatment but also for health maintenance, enhancement and optimization (Clarke et al., 2010). Biomedicalization regulates bodies not only by offering

'control over' one's body through medical intervention (such as contraception), but also by 'transformation of' ones' body, selves, health. Thereby new selves and identities (mother, father, walker, hearer, beautiful, sexually potent person) become possible. (Clarke et al., 2003: 182)

According to Clarke and colleagues, the addition of the prefix 'bio' to 'medicalization' produces a concept that encompasses

the transformations of both the human and nonhuman made possible by such technoscientific innovations as molecular biology, biotechnologies, genomization, transplant medicine, and new medical technologies. (Clarke et al., 2003: 162)

A significant proportion of scholarship in this field takes a feminist approach to biomedicalization, in part because of the commitment to feminist health scholarship by those who developed the concept. As Mamo and Fosket put it, 'female corporeality and subjectivity are understood as constituted in and through (cultural) practices of (techno)science' (2009: 927). That is, bodies are simultaneously 'objects and effects of technoscientific and biomedical discourse' (Mamo and Fosket, 2009: 927). Biomedicalization has been employed to examine how gendered subjectivities and forms of embodiment are produced in lesbian practices of assisted reproduction, breast cancer prevention technologies, pharmaceutical interventions for male erections, and contraception/menstruation (see Fosket, 2004; Mamo, 2007).

Proponents of biomedicalization argue that, whereas gender is conceived of categorically in medicalization scholarship, gender is an effect of power, 'produced in relations'. This conception of gender is aligned with postmodern feminist scholarship in which gender is not a stable, given status but an outcome of performance. Gender is also not a privileged status, but one that is produced in intersections with race, 'class, sexuality, disability, and so on' as a result of 'selective and uneven biomedical efforts to transform, regulate, and optimize bodies and futures' (Clarke et al., 2010). Although the concept of biomedicalization does not necessarily privilege gender, it takes gendered bodies seriously. To date most scholarship in this field has given attention to the study of biomedicalization processes in the USA and is only beginning to look transnationally. Whereas pharmaceuticalization scholarship is deemphasizing gender and emphasizing transnational processes, biomedicalization is inherently gendered but more western in its focus.

The challenge of biomedicalization for gender and medicalization studies is very persuasive. It came into being as process and concept along with postmodernity, and is capable of tracking multistranded workings of gendered power and knowledge. At the same time, because biomedicalization has begun to circulate so recently, maybe it is too soon to know how fully it captures what is going on in the postmodern world and to know whether it will take off and be taken up among scholars in the way medicalization has.

Geneticization

Geneticization is a concept proposed in the early 1990s by Abby Lippman to capture a new way of seeing and solving problems that reduces individual differences of race, gender and nationality to DNA codes:

[It is] an ongoing process by which differences between individuals are reduced to their DNA codes, with most disorders, behaviors and physiological variations defined, at least, as genetic in origin. It refers as well to the process by which interventions employing genetic technologies are adopted to manage problems of health. (Lippman, 1991: 19)

Lippman observed that in popular discourse genetic variations were increasingly defined as problems for which there were medical solutions. At the time when she proposed the concept of geneticization, prenatal testing was the most widely used and familiar genetic activity; Lippman gave attention to women's stories about prenatal diagnosis to exemplify geneticization. This line of work has continued (Finkler, 2001) and its gender dimensions expanded to include men and men's stories about their responses to premarital carrier matching and other genetic tests (Raz and Atar, 2004).

Scholars disagree about the extent to which the processes of geneticization and medicalization overlap, but all of them agree that there are important differences between the two. Gusterson (2001: 252) argues that medicalization 'cannot convey the novelty and power' of the processes and a new way of seeing made possible by genetic research. Conrad distinguishes between medicalization, which does not 'require specific claims about cause, although the assumption is often biological' and geneticization, which 'is very specific about where at least part of the cause lies' (2000: 329). In a recent study of the relationship between medicalization and genetics in mental illness, homosexuality and susceptibility to chemical exposures, Shostak and colleagues (2008: S310) identify different patterns: 'genetic information does not always lead to geneticization, nor does geneticization inevitably lead to medicalization.' But where geneticization is a useful concept for us lies in its potential to link both gender and transnational processes of medicalization. For example, the development and circulation of Assisted Reproductive Technologies, so important in the

development of geneticization as a concept within a US/western framework, has been recently studied in a range of different populations, from lesbians in the USA and UK, to Bedouin Muslim women in Israel, and throughout the world (Inhorn, 2006; Mamo, 2007; Raz and Atar, 2004).

Conclusion

We have argued in this chapter that medicalization is a capacious concept, but it does not fully capture the related but unique processes of biomedicalization, pharmaceuticalization and geneticization, especially when examining issues of sex, gender and sexuality in relation to health and healthcare. There is certainly a fair amount of overlap, but even such a powerful term as medicalization is not quite adequate to fully capture what is going on in the globalized world at the start of the 21st century precisely because its very definition is rooted in modernity and categorical thinking. At the same time, the concept of medicalization is worth holding on to. It is widely accepted and employed not only among scholars but also among the public. It wields cultural authority and can explain how control over medical phenomena is produced, accomplished, resisted and transformed. Its connection with modernity and modern processes of control, regulation, knowledge and power make its reach and impact partial. In a world where postmodern forms of knowledge and power circulate, medicalization as a process is too simple and as a concept too narrow for capturing the gendered circulation of pharmaceuticals, genetics and technoscience. We argue that we still need to use the concept of medicalization as our starting point or analytic wedge to explore the larger question of 'what has happened to gender?'

Early critiques of medicalization repeatedly demonstrated its gendered dimensions by pointing out how and why women's bodies, life cycles and experiences are more likely to be medicalized than men's. As we have argued, connections between women's health and medicalization continue to be a rich resource for scholarly work, but more recent critiques have expanded the category of gender to include boys, men and transgendered people.

In the social sciences and the history of women's health, there is a long and established tradition of explaining the medicalization of women's bodies. Women have been both active participants in this medicalization and the object of sexist, racist and class-based policies and practices, especially surrounding reproductive issues. These gendered concerns have continued and elaborated with the conceptual tools offered by pharmaceuticalization, geneticization and especially biomedicalization. In addition, gender scholars have pushed the binaries of sex/gender/sexuality, and their work has informed that of medicalization scholars. The real danger, however, arises if this expansion allows scholars to turn away from the study of women and the various ways that the

new processes of biomedicalization, pharmaceuticalization and geneticization continue to impact women as well as men, and trans and intersex bodies. With the disintegration of categorical frameworks and the expansion of subjectivities, how can gender be privileged and women included?

Although scholarship about medicalization is generally sharply critical, medicalization is not always a bad thing. For example, for those women globally who want to become mothers, participation in medicine (technology, services, knowledge) can be a strategy to accomplish what they perceive to be in their best interests. Childbearing is a key practice; evidence repeatedly shows how, why and with what consequences women seek medical assistance to achieve (biological) motherhood. In this case, medicalization is strategic (Inhorn, 2006). Additionally, new subjectivities are produced through the processes of medicalization and the conceptual frameworks for understanding them. These include 'transsexual', 'naive subjects', and 'pharmaceutical or therapeutic citizenship'. As Lock relates,

paradoxically, [the process of] medicalization has actually promoted ... reflection by presenting people with choice, although globalization rather than medicalization per se has no doubt been the major driving force for change. The result is that older hegemonies have crumbled, only to give way to new ones, most often in the form of knowledge that comes under the rubric of science. (2004: 119)

Medicalization is sometimes, but not always, the right tool for the job of understanding complicated, global, multi-sited processes of gendered biomedical transformations today. Gender shows us how and why we need to fine-tune our thinking when we try to understand, intervene in, and improve healthcare. By continually expanding the concept of medicalization we risk losing its power to capture the processes and consequences of defining problems in medical terms and using medical interventions to treat them. At the same time, without the nuance provided by concepts such as biomedicalization, pharmaceuticalization and geneticization, we also risk losing the ability to capture these very real processes. Medicalization is a capacious concept that is a beginning but not the end of understanding gender and the medicalization of health and healthcare.

Summary

- Medicalization theory has shifted away from the initial focus on professional dominance to include active participation of patients/consumers.
- Medicalization theory has expanded. It has moved away from its initial focus on women to include men and it has moved away from a

dichotomous view, for example, of homosexuality/heterosexuality, to sexualities that include trans and intersex.

- Medicalization is now a global process.
- The processes of geneticization, pharmaceuticalization and biomedicalization overlap with and extend beyond the processes of medicalization.

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