Conrad, P.

Brandeis University, USA

Thursday the 16 September 2004 at 17.20 - 18.05

Exhibition Centre P/X001

THE SHIFTING ENGINES OF MEDICALIZATION

Social scientists and other analysts have written about medicalization since at least the 1970s. Most of these studies depict the medical profession, interprofessional or organizational contests, or social movements/interest groups as the prime movers toward medicalization. This paper contends that changes in medicine in the past two decades are altering the medicalization process. Using several case examples, I argue that three major changes in medical knowledge and organization have engendered an important shift in the engines that drive medicalization: biotechnology (especially the pharmaceutical industry and genetics), consumers, and managed care. Doctors are still gatekeepers for medical treatment, but their role has become more subordinate in the expansion or contraction of medicalization. Medicalization is now more driven by commercial and market interests than by professional claims-makers. The definitional center of medicalization remains constant, but the availability of new pharmaceutical and potential genetic treatments are increasing drivers for new medical categories. This requires a shift in the sociological focus examining medicalization for the 21st century.

Green, J.

London School of Hygiene & Tropical Medicine

Saturday the 18 September 2004 at 11.40 - 12.25

Exhibition Centre P/X001

PROFESSIONS AND COMMUNITY

Contemporary public policy in the UK is now typified by an acknowledgement that tackling inequalities requires complex action, and that this action is likely to be most effective if based on both evidence of effectiveness and on local consultation and participation. Complex policies such as Sure Start and the Department of Health's Tackling Health Inequalities have implicit if not explicit aims of redressing social inequality through building social capital within the 'vulnerable' or 'disadvantaged' populations they target. There is of course an underlying tension between the need for centrally dictated evidence-based policy to meet national headline targets and the normative call for local partnerships that will 'empower' local people to decide their own priorities for action. This tension has been widely discussed in the literature. However, a more fundamental barrier to the likely success of current policy initiatives lies in the shifting nature of relationships between professionals and the populations they once served and are now asked to 'target'.

This paper explores some of the implications of the increasing separation, socially and geographically, of professionals and those 'targeted' communities. Few professionals live within the communities who use their services, or actively engage in the networks which would provide access to 'vertical' social capital for non-professionals. Narratives of professionalism now stress evidence-based and protocol driven practice, rather than responsiveness to local need, and construct 'professional identity' as a 'defence' against the stresses of providing services. The social segregation of professionals and communities hardens social class divisions, which are reproduced at the micro-level in every encounter between a professional and a member of a 'targeted' community. Most significantly, in relation to health and healing, this segregation diminishes the potential for empathy across social divides, breeding paternalism in the provision of