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A New Time of Reckoning, a Time for New Reckoning: Views on Health and Society, Tensions between Medicine and the Social Sciences, and the Process of Medicalization

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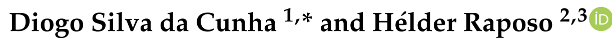

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Abstract: This article seeks to capture variations and tensions in the relationships between the health–illness–medicine complex and society. It presents several theoretical reconstructions, established theses and arguments are reassessed and criticized, known perspectives are realigned according to a new theorizing narrative, and some new notions are proposed. In the first part, we argue that relations between the medical complex and society are neither formal–abstract nor historically necessary. In the second part, we take the concept of medicalization and the development of medicalization critique as an important example of the difficult coalescence between health and society, but also as an alternative to guide the treatment of these relationships. Returning to the medicalization studies, we suggest a new synthesis, reconceptualizing it as a set of modalities, including medical imperialism. In the third part, we endorse replacing a profession-based approach to medicalization with a knowledge-based approach. However, we argue that such an approach should include varieties of sociological knowledge. In this context, we propose an enlarged knowledge-based orientation for standardizing the relationships between the health–illness–medicine complex and society.

Keywords: medicalization; knowledge-based approach; medical dogmatism; medical skepticism; medical imperialism; sociological imperialism; sociological objectivism; sociological subjectivism; pharmaceuticalization; therapeuticalization

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1. Introduction

Since the mid-20th century, strong fluctuations have been identified in the discourse on the 'health–illness–medicine complex' (HIMC), to use Renée C. Fox's accurate formulation [1] (p. 10). The renowned social historian of medicine Roy Porter opens his proposal of a medical history of humanity by saying, "these are strange times, when we are healthier than ever but more anxious about our health" [2] (p. 3). In the last chapter of his book, he repeats this idea, writing that "the irony is that the healthier Western society becomes, the more medicine it craves" [2] (p. 717). There are many factors to consider in the oscillations in the discourse on the HIMC and several available theoretical perspectives and analytical models to explain them. The medical journalist James Le Fanu treated Porter's irony as a paradox composed of four growing layers: physicians' own disillusionment with medicine, general public's concern with health, the resort to the so-called alternative medicines, and the costs of health care [3]. According to Le Fanu, each of these layers can be seen as a facet of the pattern of the historical development of modern medicine.

Le Fanu's central argument is that this development followed the standardized up and down narrative that serves as the title of his book, *The Rise and Fall of Modern Medicine*. In the post-war years, roughly from the mid-1940s to the late 1970s, the development of

clinical research as applied science, drug discovery, and technological innovation would spark the rising movement. From the late 1970s onwards, there would be exhaustion of these forces and a break in optimism surrounding modern medicine. This rupture would have produced, in turn, an empty space to be filled in the early 1980s by two emergent projects.

On the one hand, 'The New Genetics' is a project based on molecular biology and comprises the application areas of biotechnology or genetic engineering, genetic screening, and gene therapy. On the other hand, what the author calls 'The Social Theory', basically epidemiological studies, considers cultural, social, and economic conditions of health and works through statistical inference. These two projects supposedly brought a new notion of the etiology of disease, the first guided by a naturalistic and reductionist perspective, focused on genes, and the second guided by environmental and social conditioning. Solutions based on genetic manipulation and social engineering followed these notions, namely technological treatments and social prevention, respectively. For Le Fanu, these projects failed mainly because their etiology was wrong. According to him, the causes of diseases are not genetic nor social, but biological, determined by age, or simply and above all, unknown. The lack of this perception would have represented the downfall of modern medicine.

As with other interpretive generalizations, this narrative is not entirely false, but it simplifies a much more nuanced reality. Although Le Fanu's work contains pertinent criticisms of the geneticist enterprise, his perspective seems to be deeply conditioned by the very model of clinical medicine that he seeks to defend, which mainly skews his understanding of social theory but also limits the very conception of medicine. We are undoubtedly facing a transition in the discourse on the HIMC. Nevertheless, to understand what is specific in this transition and in a new discourse on the HIMC, it is mandatory to start by questioning not only what is new in our objects of study but also the limits of our old perspectives and methods of analysis. This is not equivalent to accepting the anti-realist and even nominalist theses that are still present and dominant in some sectors of the social sciences. "The key task for medicine is not to diminish the role of the biological sciences in the theory and practice of medicine", as Leon Eisenberg and Arthur Kleinman wrote, "but to supplement it with an equal application of the social sciences" [4] (p. 11). "The problem is not 'too much science', but too narrow a view of the sciences relevant to medicine", they add [4] (p. 11).

From our point of view, it will be necessary to begin by realizing that the relations between the HIMC and society are not strictly formal. They are inscribed in multilevel conditions and variations and are crossed by several agonal tendencies, as the COVID-19 pandemic crisis has recently shown. Those conditions and variations and these tensions do not allow the idea of a social theory to be reduced to epidemiology and a quantitative approach, nor to the medical fields of public health or social medicine. If, on the one hand, there is no systematic, coherent, and, above all, consensual theory that relates the HIMC to society, on the other hand, concepts, hypotheses, and theses, implicit or explicit, about this relationship are abundant.

More specifically, the social components of the discourse on the HIMC seem to find expression in, or at least are consistent with, some of the constitutive assumptions of the various subdisciplines of the social sciences dealing with research on health and medicine. As can be seen by the efforts of synthesis undertaken in authoritative works such as Deborah Lupton's *Medicine as Culture* [5] or Marc Berg and Annemarie Mol's *Differences in Medicine* [6], there are among these subdisciplines, including medical anthropology, history of medicine, sociology of health, political economy of medicine, or even strict domains of STS, cultural studies, and media studies, a discipline-oriented division of work, the construction of peculiar research traditions, but also remarkable convergences of contemporary epistemological transformations.

In this article, we are interested in considering those conditions, variations, and tendencies and these transformations. Beyond the excessive analytical segmentation resulting

from any division of labor, which produces approaches that are not only distinctive but tend to be captive to an insularity that makes reciprocal understanding difficult, we believe that it is possible to demonstrate that the new discourse on the HIMC follows, and is followed by, epistemological transformations transversal to the diverse social sciences, or to social theory in a broad sense. Some of these transformations escalate disputes on the meaning of health and illness, the limits of medical authority and the autonomy of patients, or even on broader aspects of the entire social structure. For some social scientists, as in the case of Vicente Navarro, it is the very flux of social and economic transformation, namely the accumulation crisis of capital, that produces crisis in the field of medicine [7].

In the face of specificities of this type, we must take into account that, as Graça Carapinheiro points out, the meeting between sociology (but perhaps we can generalize it to other social sciences) and health is presided over by the idea that health problems cannot be treated exclusively from the perspective of medicine, by the hypothesis that these problems require a collaborative effort that challenges the organization of knowledge and the division of professional work, and by the need to develop a critical epistemology that opens the causal nexus of pathological facts [8].

In this paper, we will sustain as a central argument that the concept of medicalization and the development of a theoretical, empirical, and critical movement called 'medicalization critique' constitute a paradigmatic illustration of the problematic coalescence of perspectives between the HIMC and society. We also believe this occurs in accordance with the previously mentioned epistemological transformations, as that concept and this movement incorporate problems inherited from fundamental tensions inscribed in the relational variability characterizing the relationship between the HIMC and society.

Let us summarize our argument according to the structure of the present paper. It is constituted of three main parts. Along them, we carry out several theoretical reconstructions, reassess and criticize established theses and arguments, realign known points of view according to a new theorizing narrative, and also propose, as necessary, some new notions.

In the first part, Sections 2 and 3, we will analyze epistemological problems transversal to the development of the history of ancient science, modern medicine, public health, medical anthropology, history of medicine, sociology of health, philosophy of medicine, and STS. We will argue that relations between the HIMC and society are not formal–abstract, or historically necessary but material and conceptual, developed at various levels, inscribed in cognitive, historical, cultural, and socio-structural variations and values. We will demonstrate the antiquity and diversification of the tensions between what is understood by the HIMC and society, showing that they are part of the Western medical tradition.

In the second part of our text, from Section 4 to Section 8, we recapture medicalization critiques following the problems and the epistemological transition exposed. We will show that this movement faces problems inherited from fundamental tensions inscribed in the relational variability mentioned above. However, at the same time, it follows and stimulates the transformation in the discourse on the HIMC, providing features that allow new heuristics in this regard. Our aim is not to reshape the concept of medicalization but to suggest a new synthesis of medicalization critique, reconceptualizing it as an already established but poorly defined set of modalities of the same process. The first will be the negative modality of medicalization, based on the concept of social control and characterized by repressive realism. Exploring the discussions around imperialism, we will argue, on the one hand, that medical imperialism corresponds to the professional variant of this first modality, and that, on the other hand, by reformulating the critique impetus and considering sociological analysis as an extension of professional imperialism, it renews and deepens the variations and tensions represented by medicalization critique. A positive modality of medicalization, still supported by the notion of social control, will be thematized from the convergence between social constructivism and the social and historical interpretations of Michel Foucault's works. This modality implies a shift from professional analysis to the analysis of power relations and forms of knowledge, which implies the recognition of the productivity of these forms and the adoption of a corresponding anti-realist point of view, which contrasts

with the natural–scientific force of Western medicine. The expansion of medicalization studies will imply reassessing new critical scrutiny, and analytical contributions, namely the accusation of biophobia, and including new structures, new agents, new behaviors, and new dynamics also explored not only by the concepts of moralization and misinformation but by concepts such as biomedicalization, pharmaceuticalization, therapeuticalization, or complementary and alternative medicalization (camization).

Finally, we will consider the proposal of replacing a profession-based approach with a knowledge-based approach, excluding the concept of social control from the semantic field of medicalization. However, we consider that a knowledge-based approach should not be sustained only in recognizing the variability of medical knowledge but also include the variability of sociological knowledge. Thus, in the third part, consisting of Sections 9 and 10, we make a case for what we can call an 'enlarged knowledge-based approach'. Such broadening involves questioning the intersection of commonplaces between medicine and the social sciences and increasing the dose of sociological reflexivity. This reflexivity will not, however, be merely professional but relative to sociological knowledge in its own variations. In this context, we can finally propose an orientation for standardizing the problematic relationships between the HIMC and society according to parameters related to the possibility of medical knowledge (skepticism and dogmatism) and related to the perspective on societies (objectivism and subjectivism).

This proposal does not exhaust the diversity of theoretical approaches but organizes them through a correlative conceptual scheme. We are not just living in the new time of reckoning Eliot Freidson alluded to, referring to the need to respond to the reckoning being made of health institutions, educational institutions, and welfare services, overlooked by commercial enterprises [9], but in a time for new reckoning, an epoch that simultaneously demands comprehensive empirical knowledge, but also profound theoretical redefinition, and sophisticated critical sensitivity.

2. The Health–Illness–Medicine Complex and Society

Nothing general can be said about phenomena as general as those of health and illness. This limitation does not arise from endorsing a relativist epistemological point of view—this is not even our case. Instead, it is an epistemological consequence resulting from the very structure of reality. On the one hand, these words, 'health' and 'illness', seem to describe universal conditions of human existence: all human beings are potentially subject not only to what we call illness but also to related circumstances such as malnutrition, aging, pain, suffering, or even death. Additionally, every human being is also, we must add, a potential subject of therapies. Nevertheless, we do not relate only empirically to these aspects, as, on the other hand, we have peculiar representations of them. We select, organize, and frame them according to different value systems and carry out diverse correlative practices. However different our conceptions may be, each of us, at each time, under each cultural bond, within each social formation, within the framework of different political regimes and forms of economic organization, has ideas about what a body is, perceptions, representations, beliefs, and even knowledge about what it is to be healthy or sick, practices and values about how to nourish, care, and cure, and how to deal with aging and death.

Thus, the space described by the terms 'health' and 'illness' is unavoidable and presumably warranted but, at the same time, highly fluctuating. As Gary L. Albrecht, Ray Fitzpatrick, and Susan C. Scrimshaw say in the introduction to the *Handbook of Social Studies in Health and Medicine*, "Health is one of the most vital but taken-for-granted qualities of everyday life" [10]. In the new edition of this book, published 20 years later as *The SAGE Handbook of Social Studies in Health and Medicine*, Scrimshaw, along with Sandra D. Lane, Robert A. Rubinstein, and Julian Fisher, wrote that "Disease, illness, and conceptions of health are complex, interrelated phenomena", whereby "simple explanations of these phenomena give only partial insights into them", leading to "inadequate and poorly fitting policies or interventions" [11] (p. 7). Faced with the COVID-19 pandemic,

the authors emphasize “the need to shift from seeing problems to be solved in an insular way to accepting that these are complex and evolving challenges” [11] (p. 11).

According to Bryan S. Turner, precisely because they express vital assumptions, notions such as those of health and illness are linked to the structure of power relations and the set of values of a society, aligned with moral and theological concerns [12]. We might add that these concerns are followed by fantasies, aesthetic sensibilities, cultural codes, and metaphorical resources [13]. Nevertheless, more than being systematically developed, the idea of value-ladenness finds expression in different theoretical frameworks of reference, study hypotheses, and particular concepts.

For instance, as the theme of the social regulation of the body theorized and investigated by Friedrich Nietzsche, Sigmund Freud, Marcel Mauss, Charles H. Cooley, Norbert Elias, and Erving Goffman and recovered by Thomas Scheff and Turner himself within the scope of medical sociology demonstrates, we are not only in the field of representations, but in a context of mediation between the biological, the psychic and the social, all this mixed with culture, morality, and religion [14–17]. In this sense, we could understand the notions of health and illness in the light of Marcel Mauss’ Durkheimian concept of ‘total social fact’, as complex transversal realities subject to multiple approaches, including biomedicine, without exhausting the very understanding of those notions [18]. It will thus be very difficult, as Turner argues, retrieving Walter B. Gallie’s concept of ‘essentially contested concepts’, to establish a cross-cultural consensus between what is meant by ‘health’ and ‘illness’, or to define a corresponding rigorous history [12].

Just as nothing general can be said about health and illness, it is also difficult to speak of medicine in general terms. Medicine, being associated with human vital and existential problems, also seems to be inscribed in the variability of such notions and to be conditioned by its resulting tensions. Bearing in mind that, alongside a widespread structure of health beliefs, as the medical anthropologist Arthur Kleinman suggests, there is also a widespread “institutionalization of decisive therapeutic practices”, the institutionalization of care processes and systems of healing, it would be possible to think about medicine itself as a “universal in human organizations” [19] (p. 15). Kleinman considers that, regardless of cultural differences, there are similarities between these systems, namely disease diagnosis categories, forms of symbolic interpretation of disease, pathology, and therapeutic practices (including idioms, metaphors, and narrative structures), healing roles, discursive strategies, or symbolic and practical operations to control symptoms.

Nonetheless, the substantive differences between conceptions, practices, and values seem to be more severe than those structural similarities. This is certainly a legacy of the variability of the very notions of health and illness, both fundamental in the scope of diverse aspects of medicine. In this sense, it can be said that, like the former notions, medicine will also involve social totality, being crossed by significant cultural and historical variability, and undergoing generalized conceptual contestation. In fact, the concept of total social fact has already been evoked to describe the COVID-19 pandemic [20].

The recognition of socio-cultural conditions of health and illness is not entirely new. There is an abundance of relevant works from various disciplinary areas that seek to elaborate historical reconstructions of particular disciplines or subdisciplines related to health and medicine, showing us a common set of variations in the respective representations, practices, and values. Among other circumstances, such works demonstrate the transhistorical awareness of socio-cultural aspects as factors that positively or negatively condition, or even determine, health and illness. This notion was already partially conscious, at least since classical antiquity. Furthermore, it has developed and integrated more social and academic groups over the centuries, according to a particular set of transformations. Among these, we must count the threats posed by communicable diseases, namely from epidemic and pandemic events, and the respective structural control responses, scientific and technological changes, developments in religion, morality and manners, the regionally differentiated processes of modern state formation, economic metamorphosis and the

corresponding organization of power relations and class struggle, and correlative changes in the supply and quality of food and water, housing, sanitation, and medical care.

Theoretically systematic, empirically grounded, well-argued, and now profusely studied examples are George Rosen's *A History of Public Health* and Samuel W. Bloom's *The Word as Scalpel: A History of Medical Sociology* [21,22]. Rosen begins his book by exploring ancient worldwide sanitary ideas and practices, including those within the framework of ancient Eastern civilizations. However, as Bloom will argue, based on a long ballast of historical evidence, there will be for centuries, inside or outside the Western world, the absence of an "effort to develop a systematic theoretical basis for the administrative program of public health" [22] (p. 22), "the systematic investigation of these relationships and the institutionalized expression of such ideas in public policy" [22] (p. 14). Both authors demonstrate that awareness of social and economic conditions of health is very old, that the problems of community life highlighted facets that today fit within the framework of the notion of public health, but that only from the Renaissance onwards did the conscience about these conditions expand.

Particularly important is the thesis advanced by Rosen, endorsed by Bloom, according to which from the 16th to the 18th centuries, the political and economic doctrines of mercantilism, or cameralism in Germany, and its respective conception of society, were structuring the formation and development of the state and the concomitant centralization of the national government. Seeking to place social and economic life at the service of the state, it was understood that it was necessary to protect the health of individuals and groups, making health a fundamental topic of public policy. Both authors also emphasize the importance of the struggle for recognition of the constraints caused by economic and technological developments in the health of the poorest and working classes. It is a struggle that dates back at least to the 15th century, being deepened after the Industrial Revolution, with increasing morbidity and mortality among the poor, a problem, as Bloom argues, that economic liberalism was not able to resolve because poverty was considered as part of the natural and moral order. According to Bloom, it is only the report to the Poor Law Commission prepared in 1842 by Edwin Chadwick that breaks with this perspective. In this regard, one cannot ignore, in our view, the contribution of Karl Marx himself in formulating his critique of political economy and his economic theory in the first book of *Das Kapital*, namely in the chapter dedicated to the discussion of the working day [23].

During the 19th century, according to Bloom, social medicine or public health began to emerge as a branch of medicine that identified the need to understand medical problems from the idea of a reformist social science, under the name of Chadwick in England, but also Rudolph Virchow or Salomon Neumann in Germany. However, the institutionalization of this area would have regional variations and would be generically deferred to the turn of the century. Even so, according to Bloom, the absence of systematic effort and its institutionalized expression would only be overcome with the emergence of medical sociology.

We must add, despite the relevance of these disciplinary areas that, in the wake of the recognition of the importance of cultural, economic, and social factors in the etiology of the disease by physicians and epidemiologists in the early part of the 20th century, the study of what can be called the binomial 'health and culture' has become common among certain empirical trends of social research. In line with some substantive issues within foundational anthropological works and with the practical orientation of ethnographic fieldwork and participant observation, medical anthropology became the main disciplinary formation responsible for comparative, cross-cultural studies on health, health behavior, practices, systems, and medical care [24]. Especially important in this regard was, through unavoidable works such as those of Kleinmann and Charles Leslie, the definition of 'medical systems' and 'ethnomedicine' as the basic units of anthropological analysis, the approach to the various representations of illness as 'explanatory models', as the concomitant composite understanding through the concept of 'medical pluralism' [25–28].

From an early age, medical historians also understood that, both in terms of theorization and analysis, the history of medicine would necessarily have to integrate cultural, social, and economic conditions. The biography and intellectual and institutional work of Henry E. Sigerist demonstrate this. He wrote, "medicine is the most closely linked to the whole of culture, every transformation in medical conceptions being conditioned by transformations in the ideas of the epoch" [29] (p. 103). This aspect is particularly distinctive and created specific tensions with the historiographical orientations prevailing in other areas, namely in the history and philosophy of science, which has produced a direct controversy between Sigerist and George Sarton, the founder of this area [30–32].

There seems to be, in a way, an epistemological anomaly here since, while serving as foundational concepts for medical science, health and illness are also more general representations; they are notions endowed with values and closely related to certain practices. However, this is not an anomaly but a constitutive tension. At least since ancient Greece, medical vocation deals with the recognition of difference but also of peculiar fusion, to use Stephen Toulmin's terms, between the theoretical and the practical, the general and the particular, the universal and the existential [33]. While aiming at the great scale of the universal, medicine is linked to the mundane world, to the problems of human existence. That is why, even if we do not subscribe to a relativistic frame of reference, we must recognize the relativistic lesson that many of the non-scientific notions available in the field of health are not even properly pre-scientific, having different relationships with scientific theories. They can even be, to use a concept elaborated by Ludwik Fleck, 'proto-ideas', that is, not only ideas that further turn scientific but also a kind of ideas that remain in scientific substance as guiding principles, let alone subconsciously [34].

The constitutive distinction between the universal and the particular in medicine structured the humanist medical tradition [35,36] and, following medical humanism against technicism, maintains a great philosophical relevance in the face of the hegemonic threat of Western mercantile technoscience, namely in particularly sensitive cases of the transformation of nature and the human condition, where there is no need for intervention to preserve life, such as cosmetic surgery, human experimentation, some cases of genetic engineering, liberal eugenics, certain situations of human enhancement, some clinical scenarios of decision making, or even in some cases of normative, prescriptive, or regulatory health frameworks, whose critiques sometimes coincide with those of the critique of medicalization that we will explore later [37–47].

There are several grounds where we find the transposition of this foundational opposition. The scope of the analytical philosophy of health and medicine has been marked by a strong opposition that, in its own way, has transposed that distinction into a debate on the values associated with the medical and social conceptions of health and illness. This focus on values results from several developments in the natural sciences, in technologies for medical use and in medical practice, transformations in the fields of philosophy of science and philosophy of biology, and applications of the orientations known as analytic philosophy and phenomenology.

In particular, the debate was somewhat launched by the works of Christopher Boorse and was largely built around the commentary on Boorse's article "Health as a Theoretical Concept", published in 1977 [48,49]. In confrontation are, on the one hand, value-excluding naturalists, or neutralists, who, as in the case of Boorse's analytical approach and biostatistical theory of health, argue that the concept of health is determined by biology and is, therefore, a value-free notion. On the other hand, the value-entailing descriptivists, or normativists, for whom, as in the case of Lennart Nordenfelt's action-theoretic approach and holistic theory of health, health depends on elements of human agency, for whom assessing whether the sick subject can reach his vital goals is, therefore, a value-laden or value-relative notion [50,51]. Although the arguments on each side of the dispute remain the same, intermediate positions have been defended. It is worth mentioning K.W.M. Fulford's proposal of a bridge theory of illness, an advocate of values-based practice, for whom concepts of disease and social conceptions of health are structurally interdependent,

as demonstrated by the fact that Boorse's theory implies evaluations, not being value-free, and Nordenfelt's theory implies biological criteria, not breaking with a certain dimension of scientific objectivity [52,53].

The same ground has also been plowed by physicians, philosophers, and social scientists who, independently but with numerous conceptual points of contact, have advocated a conceptual distinction between disease, on the one hand, as an objective abnormal condition based on the analysis of biological structures, functions, and changes, and illness as a subjective, or intersubjective, experience, whose analysis depends on psychological and social factors (e.g., [54,55]). In the context of the debate on values, the former would be value-free, while the latter would be value-laden.

At no point does the recognition of the value-ladenness or the contested nature of the notions of health and illness imply the rejection of the theoretical content of a natural-scientific point of view on these notions, nor the acceptance of a contrary approach, holistic, which links these concepts to all human life, paradoxically strengthening the processes of medicalization considered below. This discussion on values is crucial here, as it signals that the conflict generated around the HIMC does not reside only in ideas or representations but also in values, including the values that govern the selection of certain ideas or certain representations, to the detriment of others. This has been a subject insufficiently appreciated by social scientists. Despite those philosophical discussions, in the framework of the diverse social sciences, the idea of value-ladenness of health is mainly consensual but is broadly taken for granted. What is needed, for now, is to frame and organize the perspectives we have in more general frames.

For example, for Turner, following Mary Douglas, all these kinds of complexity seem to be able to be controlled by grasping the development of historical and cultural schemes around these categories and the respective phenomena, processes, or experiences they designate [12]. The reflexive transformation of these notions into systematic concepts implies a process of secularization, framing in scientific theories, the differentiation of several levels of conceptual application (such as physical health and psychological health), and the mutation of corresponding treatment practices among other aspects. This scheme helps to reduce the complexity of the contested concepts of health and illness (or even disease), but as soon as medicine is considered, one is again faced with a great increase in complexity.

These relatively introductory remarks allow us to understand that the relationships between the HIMC and society are complex, but they are not ideal formal relationships. They are not purely abstract nor historically necessary, but contingent-dependent material and conceptual relationships. The notions now mobilized also allow us to state that the multilevel conditions, variabilities, and tensions that characterize the relationship between the HIMC and society are not recent, nor can they be circumscribed only within a sphere of lay beliefs or rationalities. They are part of multiple views on health and medicine. For all these reasons, we can never take for granted the relationships between the HIMC and society. Anachronism and ethnocentrism are traps that we must avoid, at the cost of jeopardizing the understanding of our subject matter. We must make an effort to look at health–society relations independently, or only partially depending on, of the current medical configuration based on biology, the 'medical model' or 'biomedical model'. A less obvious effort, but one that we will also have to undertake, concerns the independence, or partial dependence, of these relations in terms of our understanding of society and, by extension, the ways in which the social sciences perceive, represent, and describe social life. In this sense, we must be suspicious of the excess offered by the biomedical model, as well as that given to us by an opposite 'social model'.

3. On the Acknowledged Internal Heterogeneity of Western Medicine

It is important to emphasize that Western medical theory, history, and practice are not homogeneous, which has long been known within the Western medical tradition and outside its borders. However, contrary to what today's dominant discourses conveyed by

supposed experts in health care may imply, more through the media than in background inquiries, the release of doubts about medicine is neither just a product of contemporaneity, nor only reactive and inorganic conspiratorial action. The doubt about medicine, not of a question about a particular medical intervention but of a broader questioning horizon, is also an important part of Western philosophical, scientific, and artistic traditions and of the Western medical tradition itself. Notwithstanding their analytical relevance and substantive contribution, from a historical–critical point of view, it is not necessary to turn to the comparative studies of health and medicine, nor to the application of the ethnographic method to Western medicine itself to assert its diversity against a supposed unity. In other words, it is not necessary to come from the outside. Not least because, from within Western medicine, the acknowledged diversity is not limited to the circumscription of conceptual or practical variations, pointing to deep and multilevel re-articulations of that founding tension between the theoretical and the practical, the general and the particular, the universal and the existential.

We can recall different analytical topics that run through the very foundations of Western medical heterogeneity. In particular, the historical transformations of medicine have been widely considered. For instance, among the various dimensions that Scrimshaw, Lane, Rubinstein, and Fisher underline in the set of methodological and epistemological complexity referring to the chapters published in the book they edited is "the importance of historical depth" [11] (p. 7). However, besides this general call for attention, the discipline of medical history has specifically established its validity, legitimacy, and practice around the historical variation of several medical topics. Considering studies on medical history, but also the history of ancient science and public health history, we can indeed discover widespread recognition of historical variabilities of the concepts of health and illness, the ontological status of the body, the etiology of disease, medical theories, clinical practice, the role of the physician, hygiene and nutrition, lay attitudes towards medicine, and the human relation to death, among other similar subjects (e.g., [56–65]).

In addition to considering cultural variations in health, illness, and different therapeutic systems, in light of these areas of study, and also taking into account medical literature and works on the philosophy of medicine, we will be able to perceive how different modes of thought coexist in a single culture. First, we can mention the historical variants of the very organization of medical knowledge, such as anatomical tradition, microscopical tradition, physiological tradition, biochemical tradition, pathological tradition, and immunological tradition [66].

Second, structural variants of the organization of medical practice and activity can be mentioned. For instance, the great historian of Hellenistic and early Roman medicine Vivian Nutton forged the concept of a 'medical market-place' to refer to the fact that medical practice in the period of classical antiquity is characterized by a logic of marketplace trade [67,68]. Contrary to what the anachronistic application of contemporary notions of public health or social medicine to ancient medicine would suggest, medicine and physicians have not always, nor in the West, been linked to public good or function. In classical antiquity, the physician had an ambivalent social status, highly dependent on his patients and patrons. With ancient medicine being a science, contact with the patient's individuality forces us to speak of a 'science of the individual' [69]. There was no formal medical education nor regulation of medical practice. In fact, medical knowledge was widely accessible, being available according to individual literacy and socio-economic conditions. Moreover, there were lay people who could dispute without barriers the opinions of physicians, and also a bunch of healers of all kinds competing for the same type of opportunities. So, the doctor had to, in Nutton's economic language, know how to sell his knowledge.

Erwin H. Ackerknecht was responsible for periodizing the development of Western medicine in a classic phase of 'library medicine', later replaced by 'bedside medicine', and in turn, changed in the early 19th century in France to 'hospital medicine', having later been succeeded by 'laboratory medicine' [70]. This distinction and the central role of French

hospitals, and specifically the Paris Clinical School, in this development remains a valid working hypothesis [71–75].

More recently, N. D. Jewson reformulated this distinction in a way that intersects the organization of medical knowledge and the organization of medical practice and activity [76]. Based on the notion of medical cosmology and the concept of the mode of production of medical knowledge, Jewson developed a correlation between the patron, the occupational role of the medical investigator, the source of patronage, the perception of the sick man, the occupational task of the medical investigator, and the conceptualization of illness. This type of conceptual proposal took on some prominence in the sociological approach, so the idea of medical cosmology shaped other analyses committed to capturing new distinctive characteristics both at the level of discourse, practices, and forms of medical knowledge. This is certainly what explains the existence of analytical proposals that, although emphasizing and problematizing different aspects of modern medicine, converge in the objective of trying to identify the dimensions that appear to be more structural in the way of thinking and doing medicine, such as 'surveillance medicine' [77], 'precision medicine' [78], and now 'digital medicine' [79], or 'translational medicine' [80]. It is the same unifying assumption that presides over those exercises.

Third, one can speak of the existence of internal ontological, epistemological, and practical variants of medical theory or, in other words, refer to the various branches of medicine in a broad sense, as for example, Hippocratic and Galenic humoralism or Louis Pasteur and Robert Koch's germ theory of disease. The range of the clusters in this regard can be highly variable, depending on the systems of classification of nature, body, disease, etc. A suitable designation to integrate these variants without disregarding them from the criteria of contemporary science lies in the expression 'medical pluralism'. As the great historian G.E.R. Lloyd recently argued from the study of Egyptian, Chinese, Greek, and Roman sources (in fact, in the explicit wake of Nutton), in the ancient medical marketplace, we find nothing but medical pluralism in the sense of complexity, diversity, and heterogeneity of practitioners and practices [81].

Different metaphysical and ethical conceptions of medicine can, fourthly, also be mentioned as one of those specific analytical topics that signal the internal heterogeneity of Western medicine. In classical antiquity, medicine, as Hans Jonas states in his great work *Das Prinzip Verantwortung*, would be the only domain of *techne* that was non-ethically neutral [45]. Given the unitary nature of the Hellenic way of life, several of these conceptions have played a structuring role in the history of medicine since antiquity. A clear example lies in the secular distinction between two dimensions of medicine, or two entirely different conceptualizations of it: medicine as a science and medicine as an art, *scientia medica* and *ars medica* [37,82].

However, this is not the only important issue in this context. As health and illness engender moral and theological bonds, metaphysical and ethical medical conceptions integrate the vast scopes of culture, morality, and politics. In this regard, it is worth bearing in mind that there is a notion of philosophy as a form of therapy being appreciated from classical antiquity to contemporary philosophy [83] and that, in the same context, especially in the frame of the *Corpus Hippocraticum*, medicine was established as what came to be understood not only as a form of humanism but also as a proper human science [22,36]. A similar meaning was accommodated by the contemporary conceptualization of medicine itself as a social science. This understanding of medicine as an art, as a human science, as a social science, or the very conception of medicine from a humanist point of view has been mainly mobilized to respond to conceptions not only more scientific but above all, more technological of medicine, having a non-negligible role in the organization of hospital services and in the articulation of, or resistance to, new movements within institutionalized medicine, such as evidence-based medicine or personalized medicine [84–87]. In turn, it is not alien to this nexus the correspondence of the idea of social science itself, especially that of sociology, with a form of medicine, a very common correspondence in the American sociological literature of the 20th century [88].

Fifthly, it will be very worthwhile to consider that doubts about medical knowledge, practices, values, and institutions and the effectiveness of the medical act are very old. In his fascinating book *The Word as Scalpel: A History of Medical Sociology*, Samuel W. Bloom places the genesis of medical sociology within the scope of a pattern of social change that includes conceptual and institutional transformations and writes that the different aspects of physicianhood "always evoked ambivalent response in society" [22] (p. 13). Of course, for the reasons outlined above, these doubts inhabit lay attitudes toward medicine from an early age to modern industrial societies. However, it is crucial to underline that there is an affinity between skepticism and medicine and that the latter is very ancient. Whatever the answer to the debates about the theoretical priority and the reciprocal influence between ancient philosophy and ancient medicine, as shown by John Christian Laursen in a recent text, "the practice of medicine and philosophical skepticism have gone hand in hand at several points in history", including authors such as Sextus Empiricus, the physician who is also the major source for ancient skepticism, or Francisco Sanches, Ernst Platner, or Martin Martinez [89] (p. 305). The most important thing to glean from this legacy seems to be not so much a closed sense of skepticism as a doctrine of radical uncertainty, but, as Maurice Raynaud points out, following Claude Bernard, the universal doubt and critical attitude that is characteristic of it, that is extended by the modern scientific spirit, and should also be present in medicine [90]. Without taking this into account, it is difficult to understand some contemporary views on health and how they articulate with, say, the self-criticism of Western medicine.

Even from a less skeptical point of view, but not less critical, there is no doubt that the results of medical interventions can be effectively ambivalent, carry error, and be followed by malpractice, which means, as abundantly documented (e.g., [91–93]), that they are not harmless or unproblematic in their effects and implications. There are, therefore, several substantive arguments for not slipping into a simple salvific exacerbation of medicine's successes or into a reified view of medicine's technical superiority. On the one hand, in the exercise of its practice, medicine is confronted with areas of indeterminacy, complexity, and contingency that signal the constitutive character of uncertainty and, thus, the always limited scope of its interventions [94]. Because the measurement of the effectiveness of this intervention is demonstrably lower than what is believed, Jacob Stegenga's recent research into medical skepticism, or even, in his own phrase, 'medical nihilism' in Western philosophical, scientific, artistic, and medical thought reinforces the importance of taking these doubts into account on a rational and argumentative level [95–97] (see also [98]).

On the other hand, despite many innovations and objective gains in health, multiple inequalities persist, reflecting structural tensions between economy, health, and politics, which means that the distribution of positive impacts in terms of health indicators is differentiated according to the hierarchical divisions of social stratification. This idea was famously presented, perhaps for the first time and within the scope of Western medicine, by Thomas McKeown, who argued that health improvement stems more from social change than from medical interventions [99–101]. Several government efforts have extended this point of view, which has crystallized in the publication of several important technical reports, such as the so-called 'Black Report' on Inequalities in Health of 1980, authored by the Department of Health and Social Security of the United Kingdom [102], and more recently in the creation of the Commission on Social Determinants of Health by the World Health Organization, with a specific research agenda (see [103]).

It is important to note that this agenda has been challenged by the explicit criticism of some of its socio-political assumptions and the search for a redefinition of the relations between the HIMC and society attentive to health structural inequalities and injustices from the individual and community recognition of the right to health [104–106]. This is happening in a macroeconomic environment with long-term growth of the gross domestic product rates of Global South nations and their statehoods, now accelerated and impacting healthcare spending [107–110]. Accordingly, the Low and Middle-Income Countries (LMICs), the South Eastern European countries (SEE), the leading emerging markets of

Brazil, Russia, India, China, and South Africa (BRICS), or the Emerging Markets Seven (EM7), the MIST nations (Mexico, Indonesia, South Korea, and Turkey), the Central Asian Republics Information Network (CARINFONET), or the Association of Southeast Asian Nations (ASEAN), have been recognized as an economic and social driving force, despite facing specific epidemiological difficulties.

4. Social Control and the Realist-Negative Modality of Medicalization

One of the classic and most consolidated currents of the social study of health, illness, and medicine explicitly expresses the variabilities and conflicts just alluded around the HIMC and society and the respective tensions between medicine and the social sciences. Early on, a substantial part of the theoretical heritage that was being developed in the context of sociology regarding the role and action of medicine followed a critical vision of the growing power and permanent expansion of the medical profession, conceived as a form of regulatory action whose more tangible effects were translated into effective mechanisms for social control of deviant behavior. One of the concepts that, in this context, gained prominence and widespread acceptance was that of medicalization. It ended up giving rise to an abundant theoretical–empirical streak. This concept takes us from the domain of the variations in the concepts of health, illness, and medicine and throws us into the field of medical feedback from society.

We believe that it is possible to sustain the thesis that medicalization critique, as a very heterogeneous movement, constitutes a paradigmatic illustration of the difficult coalescence of the perspectives between the HIMC and society and, simultaneously, the perspectives between the social sciences and medicine. It was, and maybe still is, a potential source of extraordinary theoretical inventiveness in the field of the social sciences in dialogue with medicine and an excellent base of thematic issues for thinking about the new pandemic age.

Medicalization critique today has vast intellectual patrimony. We know in our days that several authors developed the concept of medicalization, that it was inscribed in different disciplinary areas and theoretical–empirical approaches, that it integrated different political families, that it was thus still supported by different assumptions and starting hypotheses, but also that it served purposes and was developed in different contexts, that it was focused on a wide range of historical periods, empirical areas and objects, cut according to the most diverse sampling processes and interpretative horizons. This rich heritage ended up being translated into the accumulation of semantic layers around its meaning, the very definition of the term 'medicalization'.

Joseph E. Davis argues that from the 1990s onward, medicalization theorists tried to give the concept greater generalizability, but the result was excessive, causing the concept to become "a complete muddle" and lose "its way" [111] (p. 51). As Rafaela Teixeira Zorzanelli, Francisco Ortega, and Benilton Bezerra Júnior argue in a more recent article, this generalization created disagreements and great conceptual confusion [112]. Based on an excellent analysis of the uses of the term 'medicalization' by different authors and in various contexts between 1950 and 2010, Zorzanelli, Ortega, and Júnior reject the possibility of a definitive definition of the concept of medicalization, suggesting a set of possible and not necessarily excluding specific meanings of the term. Due to the need for theoretical attention and precision, without neglecting the conceptual complexity of medicalization and its cultural, historical, and local boundaries, those authors also stand for 'transitivity' as a necessary principle for the use of this concept, that is, that such use should be followed by the specification of the particular meaning of the term and the respective object under analysis.

Here, we look for what Zorzanelli, Ortega, and Júnior call the "common conceptual ground" of medicalization critique [112] (p. 1860). However, unlike these authors, we do not do so directly through the definitions established by Peter Conrad, the contemporary author who would become the main reference in the field of medicalization critique. In this text, we do not have a particular interest in the exegesis of the work of this or that author but

in the critique of medicalization understood as a whole. For this, it is perhaps not necessary to admit the transitivity of the concept of medicalization as a determining principle of the critique of medicalization, but rather to understand this critique as a historically situated movement and to ascertain to what extent the previous principle emerges, or not, from the process of conceptual formation itself.

In a chapter discussing Michel Foucault's contributions to the understanding of medical knowledge, practice, and encounter, Deborah Lupton establishes a comprehensive framework that fits the diversity of perspectives on the concept of medicalization [113]. It is from Lupton that we retain the expression 'the medicalization critique', or more especially 'the orthodox medicalization critique'. The transversal and general reading evoked by these designations allow us to capture the arguments of the original proponents, but it also enables the reassessment of new critical scrutiny and analytical contributions and the incorporation of new actors and new dynamics in the reconfiguration of what is understood as the very process of medicalization.

Following Uta Gerhardt, Lupton's genealogy of medicalization critique begins with the Marxist and liberal humanist perspectives underlying social movements emerging in Europe in the 1960s and 1970s. As justice and inequality acquired legitimacy in academic research, several authors began to underline the relevance of "individual freedom, human rights and social change" and at the same time criticize "the ways that society is structured", including the scrutiny of the "social role played by members of powerful and high-status occupational groups such as the legal and medical professions" [113] (p. 95). According to Lupton, medicalization critique would become one of the most dominant sociological perspectives in the 1970s and the 1980s, remaining largely dominant in the 1990s in Marxist, feminist, and consumerist-based works. This development implied accusing Talcott Parsons' structural functionalism, which commanded medical sociology in the previous decades, of political conservatism, namely of reproducing medical authority. As we will see, the break with the structural functionalism view of social order in general and the sick role in particular is supported by an even more general epistemological transition in sociology, mainly guided by the development of symbolic interactionism, labeling theory, phenomenological sociology, ethnomethodology, and the dialogue with the anti-psychiatric movement and several political movements [88], but it did not dispense the sociological analysis of the Parsonian account of illness as deviance.

The term 'medicalization' was coined by the American sociologist Jesse Pitts in 1968 in an *International Encyclopedia of Social Sciences* entry on the concept of social control [114] (pp. 390–392). The set of works consensually considered classic in medicalization literature includes articles, chapters, and books authored by Eliot Freidson, Irving Zola, Ivan Illich, Thomas Szasz, Michel Foucault, Catherine Kohler Riessman, Howard Waitzkin, and Peter Conrad, although some of these authors did not regularly use the term 'medicalization'. Other works of reference will be considered later in our paper, such as those of Renée C. Fox and Philip M. Strong [1,115]. However, it is important to emphasize that, in addition to the classics, different authors can be pointed out as pioneers of the movement, according to the subscribed definition of medicalization and the effective field of its application. In a brief period prior to the 1960s, even before the concept of medicalization was coined, systematized, and disseminated, some of the understanding of the process described by this concept was established within the scope of the study of the development of psychiatry and around the idea of mental illness. Some specific works of Barbara Wootton, Thomas Szasz, and Thomas J. Scheff from the 1950s and 1960s are, in this sense, identified as pioneers in the critique of medicalization [116–121]. Some of those works are cited by the classics themselves. In this sense, it can already be advanced that psychiatrization can be understood as an internal variant of medicalization and, at the same time, the 'critique of psychiatrization' as an internal variant of the critique of medicalization.

Proponents of the medicalization critique, as Lupton demonstrates, will argue in different ways that, with this process, medicine, medical discourses and practices, and also medicine allied professions and care structures become increasingly powerful, influential,

and dominant. The central thesis shared by those authors is that, following the scientification and professionalization of medicine, there was an extension of the monopoly of the field of medical practices, medical jurisdiction, and its expert authority to more and more aspects of life. Medical intervention in the management of human life has increased; its scope is indefinite and potentially ubiquitous. This idea would correspond, in conceptual terms, to the reduction of a growing set of social and political problems to medical problems, treatable according to the practices of professional medicine, namely through drug therapies.

According to each author, the focus of theorization, analysis, and criticism had been placed on different segments of this process, such as, continuing to follow Lupton, the medical error, the putative lack of effectiveness of medical treatments, or the side-effects of medical intervention, the reproduction of all sorts of social and economic inequalities in the medical encounter and in the medical definitions of illness and disease, the identification of the medical profession as a patriarchal institution, or the increase in dependence of lay people or, on the contrary, the loss of their autonomy. According to June S. Lowenberg and Fred Davis, the conceptualizations of medicalization bring together three main components: causality conceptions and locus of causality, the purview of the pathogenic sphere, and professionalized unequal status relationships between providers and clients [122].

Although we are not interested in a detailed exegesis, it is important to understand the aspects that each main orthodox author added to the concept. In Pitts' foundational text, the concept of medicalization manifests itself with transitive character; that is, it is not formulated as a general process, as medicalization as such, but specifically as 'medicalization of deviance'. This formulation resulted, on the one hand, from the analysis of social control arising primarily from the American sociological tradition and, on the other hand, from the consideration of the influence of Freudian thought since the 1920s upon the social organization of stigma and penal sanctions. Looking at illness as a pattern of deviance, Parsons' approach is one of the main sources for Pitts to correlate illness, deviance, and social control. In this context, the term 'medicalization' designates the process of "redefining certain aspects of deviance as illness rather than crime" [114] (p. 390). In the same framework, this process implies reassessing individual responsibility and assessing unconscious psychological motivation in understanding illness, followed by the respective therapeutic practice.

Therefore, in Pitts' paper, the concept of medicalization was also linked to a psychological and social dimension of illness, namely the control of people classified as mentally ill. Another crucial aspect of this first formulation is found in its critical but not entirely negative sense. Pitts accepts that there may be some decrease in individual autonomy through the medicalization process, including political castration of the deviant and threat of their civil liberties. Nevertheless, he believes that medicalization can be a more humanized method of controlling deviance than imprisonment. In his words, "social control becomes more humane and forgiving, but perhaps also more relentless and pervasive" [114] (p. 391). Pitts considers that medicalization may also be more effective than the judicial method, as the medical and paramedical professions will resist corruption and political pressure more than the judicial and parajudicial professions.

The point of view introduced by Freidson is unavoidable. As Fredric D. Wolinsky underlines, in this author's work, it is not only the issue of the emergence (and organization) of the medical profession that arises but also, as part of his theory of professions, a perspective on professional dominance [123]. Freidson, in fact, rarely uses the term 'medicalization', and when he does, implicitly or explicitly, it is framed by his theory of professions, by his empirical evaluation of the dominant autonomous professions, and fits his idea of dominance as can be seen in his book *Professional Dominance: The Social Structure of Medical Care* [124]. We cannot fail to say that in his best-known work, his book on the profession of medicine, Freidson does not even use the word 'medicalization'. It appears only in the recourse to the citation of Pitts' foundational text in the chapter "The Professional Construction of Concepts of Illness" [125]. In Wolinsky's concise and accurate

words, it can be said that the essence of the professional dominance perspective developed by Freidson has to do with two crucial aspects: the definition of the medical profession as an occupation that has achieved 'organized autonomy' or 'self- direction' and that this autonomy is structurally guaranteed, namely through formal institutions, in such a way that the profession can be self-regulating. According to Wolinsky, this perspective was addressed by the observation of a progressive erosion of the autonomy of the medical profession. The notions of deprofessionalization, mainly developed by Marie Haug, and that of proletarianization, mobilized, for example, by John McKinlay, have served to criticize the point of view of domination and thus question medical power as a professional power.

Here, we are facing an important disciplinary and epistemological event. A disciplinary event is before us; it is profoundly known but seldom recognized and rarely noted: there is an agreement between the sociology of professions and the sociology of medicine—the first is dependent on the high relevance of the medical profession in the system of professions, while the former needs a theory of professions and methods to explain and understand health care systems. Eliot Freidson's life and work, in its entirety, are the perfect example of the intersection between the sociology of professions and the sociology of health [126–128]. However, it should be noted that this relationship does not occur only in the professional domination version of the medicalization critique but in the entire scope of the orthodox understanding of this critique and the respective repressive–negative modality of medicalization. A clear example of this lies in republishing Irving Kenneth Zola's main text on medicalization in a collective anthological volume that did not include Freidson's participation, which was organized around Ivan Illich's notion of 'disabling professions' [129].

As it began to structure itself based on the experimental sciences, medicine acquired greater disciplinary coherence and a new scientific identity that was fundamental to its growing institutional power and the cultural legitimacy of the profession [130]. From the perspective of some of the authors responsible for the sociological approach to the power of professions, medicine is precisely a paradigmatic case of a profession whose institutionalization has historically translated into the ability to convert its specific and professional knowledge into organized forms of power, which proved to be fundamental for the defense of its jurisdiction [131], as it ensures a space of expertise protected from external interference from other groups and actors [125,132,133].

The emergent conventional narrative of medical sociology as a subdiscipline repeatedly associated with Parsons wrongly assumes that the theorizing heritage of the classic founders of sociology would denote an alleged alienation regarding health and illness [134,135]. Now, not only is this postulate debatable, but this whitening is particularly illuminating for the sociological project itself in terms of disciplinary institutionalization. Since its emergence as a subdiscipline, there has been a well-established division of labor between sociology and medicine. In the case of the sociological approach, specialization resulting from this division influences criticism directed at the biophysical approach of medicine, building, from there, the study of the dimensions that are excluded from the medical perspective.

The analysis privileges the social interpretation of reality, condensed, for example, in the distinction between illness and disease, fundamental in Parsons' foundations of the sociology of medicine, subscribed by Freidson and crucial as a basis for the conception of the analysis of the emergence and professional dominance of medicine [136]. It supports the assumption that medicine has the exclusive right to approach the biological body and its pathologies, while sociology strictly focuses on the social. This relegation of classical approaches has made us forget not only some sociological theories about disease, health, and mortality but also, and especially, the content of various critical approaches to the emerging biologism, vitalism, the new physiology, or pathological anatomy [137], which resulted in the gradual uncritical incorporation of the idea that the medical notion of illness constitutes a stabilized biological and physiological fact. The suppression of illness in sociological analysis can thus be understood as an illustrative indicator of the dynamics of

disciplinary differentiation and professionalization since it seeks to base itself on a focus on the social as explanatory nexus.

A crucial article for the systematic development of the concept of medicalization was published by Irving Kenneth Zola in 1972 [138]. It had an expressive title: "Medicine as an Institution of Social Control". This document resulted from a residency at the Netherlands Institute for Preventive Medicine in Leiden and a subsequent presentation at the Medical Sociology Conference of the British Sociological Association in Weston-Super-Mare, in November 1971. In this article, there is significant generalization of the concept of medicalization. The transitive character of this concept seems to be relatively dissipated by this generalization. Zola no longer speaks of the medicalization of deviance but, in his terms, of the 'medicalizing of society'.

According to Zola, the practice of medicine has always been "inextricably interwoven into society" [138] (p. 488). Additionally, this relationship is not only *de facto* but also *de jure*; that is, medicine has always had a normative role. In historical terms, Zola finds in psychiatry the main scope for dealing with social deviance and in public health a fundamental field for the transformation of diverse aspects of social life. However, the author argues that the critique of medicalization cannot be reduced to a critique of psychiatrization since the psychiatric profession "by no means distorted the mandate of medicine" and, at most, carried out this mandate at a faster pace [138] (p. 487). Zola also rejects the thesis that medical involvement in social problems removes them from religious and legal spheres, demoralizing them. On the contrary, recovering the link between the concepts of medicalization and social control, he believes medicine "is becoming a major institution of social control, nudging aside, if not incorporating, the more traditional institutions of religion and law" [138] (p. 487). Explicitly relying on Freidson, Zola highlights the relevance of the correlation between the medical profession and the jurisdiction over the label 'illness'. Nevertheless, he moves away from a reading that reduces medicalization or its causes to 'professional imperialism', understood as an intentional action by medical professionals. For Zola, medicalization is not, nor does it result from, an intentional process.

Furthermore, Zola thinks it also does not come from the medical class' political influence or political power, nor does it consist only of an expansion of medical jurisdiction. For Zola, there is indeed an extension of medical jurisdiction and an extension of the physician's power, but he understands medicalization as a more insidious issue, reaching beyond the medical profession itself. It resides precisely in "medicalizing much of daily living, by making medicine and the labels 'healthy' and 'ill' relevant to an ever-increasing part of human existence" [138] (p. 487). Zola proposes to categorize medicalization in four concrete ways. First, following the change from a specific to a multi-causal etiological model of disease, medicalization takes place through the expansion of what in life is deemed relevant to the understanding, prevention, and treatment of disease, followed by the emergence of forms of social control. Finding roots for medicalization in the "increasingly complex technological and bureaucratic system" [138] (p. 487), which fosters extreme confidence in the figure of experts, Zola cannot fail to note, secondly, that medicalization is also carried out through the expansion of the use of medical devices, medical evidence, and medical rhetoric to explain what is good in individual, social, political, and economic life. Medical judgment is not based on virtue or legitimacy but on the label 'health'. Thirdly, the same process of medicalization lies in the retention of access to taboo in areas of mental and social life, including in the medical field natural processes such as aging and pregnancy and social issues such as drug addiction and alcoholism. Medicalization thus goes far beyond organic disease; the question becomes what can be labeled as an 'illness' or 'medical problem'. We are facing a growing list of human conditions and daily activities. Many other cases of cultural, social, and political situations are mentioned by Zola, such as male circumcision, abortion, child abuse, sterilization, sex change operations, homosexuality, drug use, or dieting. Eventually, lay people themselves attribute organic problems to some of these conditions. Nevertheless, medicalization is also made, fourthly, of the retention of control over some procedures, namely the right to carry out surgery and prescribe drugs,

not only placing the body and mental life under medical care but also doing it under criteria that go beyond organic repair and include moral and aesthetic standards. Therefore, medicalization, as conceptualized by Zola, is followed by processes of moralization. The danger, for Zola, lies not only in masking these processes as strictly scientific and technical but also in being for 'our own good'.

Illich reformulated the critique of medicalization through the concept of iatrogenesis and with a frame of reference inspired by the critique of the political economy of industrialization. Other authors, namely Vicente Navarro and Howard Waitzkin [7,139], also focused on the criticism of medicalization from issues of the political economy. However, Illich's vision stands out because he is usually pointed out as the most radical critic of medicalization. He was recently appointed, together with Zola, as responsible for an 'extreme Medicalisation thesis' [140] (see also [141,142]), which we will see makes little sense when we look at the Foucauldian point of view.

In *Medical Nemesis. The Expropriation of Health*, Illich hypothesizes that there are three levels of iatrogenesis: first, clinical iatrogenesis, which concerns the undesirable effects of the medical system; second, social iatrogenesis, which concerns the sponsorship of disease by medical practice, encouraging diverse forms of preventive medicine; third, cultural or structural iatrogenesis, which is related to the inculcation of health improvement with a current value, as a commodity [143]. For Illich, iatrogenesis has become medically irreversible at each of its three levels. Illich also considers that whenever an attempt is made to avoid harm to the patient, a loop of negative institutional feedback is created, which he calls 'medical nemesis'. Illich seeks to recover the figure of Nemesis from Greek mythology. According to the author, for the Greeks, Nemesis represented divine revenge on mortals who went beyond the limits of the human, looking for what the gods kept for themselves. Nemesis was the inevitable punishment for attempts to be a hero instead of a human. As a deity, it represented nature's response to arrogance, to the individual's presumption in seeking to acquire the attributes of a god. By invoking ancestral myths and gods, Illich sought to clarify that his framework for analyzing the collapse of medicine is alien to industrially determined logic and ethos. Therefore, he rejects the use of bureaucratic, therapeutic, or ideological language.

What can be conceived as this initial vision or as the more general or orthodox perspective of the medicalization critique began with the identification of medicalization as the social–cultural and political–economic process through which the function or role of social regulation traditionally exercised by religion and law is now being carried out by medicine. It can accordingly be argued that there is a continuity between the broader processes of Western secularization and modernization and the understanding of medicalization [144]. If we consider that this process, so understood, inaugurates a new era in social development, 'the medicalization era', recovering the title of the book directed by Pierre Aïach and Daniel Delanoe, we can, at the same time, as the subtitle of the same book points out, speculate about the emergence of a new type of human, or a social specification of the species, the *Homo sanitas* [145].

Despite all the differences, the group of authors that can be considered orthodox share not only the previously mentioned thesis but also an ontological, epistemological, and normative orientation. The view subscribed by these authors is realist and negative. For them, medicalization is a real but undesirable process. As Lupton writes, "the term 'medicalisation' is generally used in the sociological literature in a pejorative manner", "to be 'medicalised' is never a desirable state of being" [113] (p. 96), "Medicalization is typically represented as negative, a repressive and coercive process" [113] (p. 106). This perspective is based on a notion of power as "a property of social groups" and in a respective concept of social control [113] (p. 106). In this context, the concept of medicalization points out the limitation of the field of freedom, thought, and action of the individual and the community to which he belongs by a dominant social, cultural, economic, and political structure. This perspective can be extended directly into a "negative view of members of the medical profession", concerning power relations, in the sense of "seeing doctors as attempting to

enhance their position by presenting themselves as possessing the exclusive right to define and treat illness" [113] (p. 96).

When we look at the previously mentioned group of authors as a whole, we see that, despite textual variations here and there, they share a set of assumptions that allow us to speak not only of a semantic sense of medicalization but of a whole modality of this process. We prefer to speak of modalities of medicalization, and corresponding versions of the critique of medicalization insofar as the expression 'modality' allows us to underline a process of a specific type as a counterpoint to a perspective on certain processes of this or another type. Talking about different modalities implies recognizing some degree of existence, which may have been discovered through specific discussions, but which is not reduced to the discursive layer that puts them in evidence.

In this case, in epistemological terms, their vision is supported by a realistic epistemological conception, followed by an explicitly critical normative conception, directly dependent on the negative evaluation of this process which is called medicalization as real. For authors who subscribe to a version of the repressive–negative critique of medicalization, such conceptions translate into the understanding of certain phenomena of the social and political order as medicalizable, while others would be of a natural, biological order—illnesses, let us say, truly acceptable as illnesses. As Thomas Szasz mentions within the opening of his book *The Medicalization of Everyday Life*, the concept of medicalization "rests on the assumption that some phenomena belong in the domain of medicine, and some do not" [146] (p. xiii). That is, for this author, there are, in fact, some phenomena that belong to this domain. The question is truly about 'over-medicalization' (see [147,148]). The example he offers us is crystal clear: "we speak of the medicalization of homosexuality and racism, but do not speak of the medicalization of malaria or melanoma" [146] (p. xiii).

In the context of such an understanding, according to Lupton, orthodox critics of medicalization end up considering that medicalization is a two-way process, being possible and desirable to diminish medical power and restore some power to lay people through demedicalization strategies. Lupton mentions challenging medical rights, knowledge, and decisions, empowering patients, promoting engagement in preventive health activities, patient advocacy groups, or even seeking the attention of alternative practitioners, and encouraging greater state regulation over the actions of the medical profession to limit its expansion or even to deprofessionalize it. Through these demedicalization strategies, lay people could 'take back control' over their own health. In this respect, critics of medicalization are very close to the bioethical discourse on patient autonomy (see [149]).

5. Medicalization and Varieties of Imperialism

We can recognize a focus of tension in the relationship between medicalization and imperialism that deserves further clarification in the critical reactions to the discourse on medicalization found in the sociological literature. In the 1970s, some sociologists began to critically limit the critical perspective on medicalization itself, addressing a specific internal tension. The best-known cases are the article "The Medicalization and Demedicalization of American Society", published in 1977 by Renée C. Fox [1], and Philip M. Strong's article "Sociological Imperialism and the Profession of Medicine—A Critical Examination of the Thesis of Medical Imperialism", published in 1979 [115].

The semantic field of imperialism is quite vast, which forces us to establish that there is a whole genealogy of imperialism that goes beyond the content of these texts and the work of these authors. According to *The Cambridge Dictionary of Sociology*, the term 'imperalism' refers to the indefinite expansion of the territorial sovereignty of a political unit [150]. Furthermore, it articulates diverse sociological and political notions, such as capitalism and colonialism. In both cases, concomitant forces are at play with imperialist ambitions of territorial acquisition and multilevel forms of control and domination. In turn, the plasticity of this type of force allows us to think about different varieties of imperialism. There is little doubt that various contemporary processes of globalization have made the cultural variety of imperialism, the so-called 'cultural imperialism', one of the most discussed.

The specific variety of what is designated by the expression 'medical imperialism' is used more sparingly, almost always going back to Strong's text, but the introduction of this formulation has been traced back to a letter by the physicians Herbert A. Schreier and Lawrence Berger, published in 1974 in *The Lancet* [151] and which Strong does not cite. In its foundational usage, the term is used widely as a synonym for colonialism, economic, and cultural imperialism. For Schreier and Berger, the term 'medical imperialism' designates "the use of foreign populations, for example, by American corporations, Federal agencies, and private foundations, for American ends" [151] (p. 1161). Starting by talking about the economic exploitation of the antibiotic drug chloramphenicol, then also referring to the tobacco industry and the use of cyclamates, those authors argue that giant multinational corporations based in the US, despite international regulation, promote sales abroad and earn billions of dollars in foreign sales of products whose internal consumption is at least scientifically contextualized or even limited.

The concept of medical imperialism was later used by several authors, including some critics of medicalization or connoisseurs of medicalization critique. Nevertheless, not all retained the same meaning. In his book, *Medicine Out of Control. The Anatomy of a Malignant Technology*, also published in 1979, the same year as Strong's article, Richard Taylor directly addressed and developed the concept as forged by Schreier and Berger [152]. Illich, in turn, understands medicalization as a form of medical colonization and refers to the letter of these authors but does not mobilize the concept of imperialism in these terms [143].

Most researchers associate this notion with another variety of imperialism, 'professional imperialism'. This variety is perfectly harmonized with the Parsonian association between social control undertaken by physicians and their belonging to a professional complex. In fact, it seems to have been from there, even if not accepting the structural-functionalist program, extended by the sociology of professions through the approach of professional analysis of medicine. This intersection in the critique of medicalization already occurred, paradoxically, after Zola argued that medicalization did not result from any professional imperialism. Such a variety may have been first formulated by Howard B. Waitzkin and Barbara Waterman, also in 1974, when they considered the international, institutional, and interpersonal levels of medical imperialism [153]. As mentioned, Freidson's life and work exemplify the intersection between the sociology of professions and the sociology of health, but the author rarely mobilized the concept of medical imperialism, having preferred to speak of professional domination.

In Fox's and Strong's works, the intersection is more corpulent, critical, and directly related to medicalization critique. We can find here an analytical autonomization of the tension between medicine and the social sciences, specifically sociology, an approximation with greater consistency than usual.

Fox puts us in front of one of the first critiques of the medicalization critique. Since this is a sociological work that does not entirely deny the medicalization critique, we are not dealing with an external critique but with what can be understood as an internal critique or a meta-sociological critique. According to Fox, the complexity of the medicalization process and its putative inconsistency, widely understood by the author in terms of the realist–negative medicalization modality, make its analysis difficult. The vast extension of the implied notion of illness does not allow defining illness itself in a strict sense, either as "objective reality", "a subjective state", or "a societal construct" [1] (p. 11). However, the author considers that the main difficulties in the analysis of the medicalization process stem from two sorts of assumptions made by critics of medicalization in America. The first is that "the central and pervasive position of health, illness, and medicine in present-day American society is historically and culturally unique" [1] (p. 13). The second is that "it is primarily a result of the self-interested maneuvers of the medical profession" [1] (p. 13). Fox believes that neither of these assumptions can be taken to be true without further clarification.

Throughout his text, he seeks to defend that younger health professionals, political activists, and also some social scientists, reacting to what they consider to be "over

medicalization" with a discursive and practical countertrend process of demedicalization, contended the historical and cultural transience of medical categories [1] (p. 17) (see also [147,148]). The very concept of illness, for example, and there is no doubt about that, is considered to vary between cultures and over time. Fox also argues that the HIMC designates a broad nexus, which involves several structures (biological, social, psychological, cultural) and institutions (economic, magic, religious, scientific), in such a way that the current process of medicalization in American society could not result exclusively from the privileged action of physicians.

Additionally, focusing on the criticism of medicalization and the advocacy of demedicalization, Fox argues that there are apparently opposite transformation movements. On the one hand, the gradual emergence of a conception of health as a right would entail major conceptual rather than structural shifts, while, on the other hand, particular effective processes of demedicalization would concern a transformation of structures and values.

Strong's text seems more relevant to us. His critique can also be considered within the framework of a meta-sociological critique of the perspective of medicalization critique. Nevertheless, it operates from a reformulation of this perspective. In this sense, it is also, shall we say, a sociological meta-critique. Strong's starting point is to reformulate not the process of medicalization in any applied sense or directed to any particular condition, but in a very vast sense, also here coincident with the realist–negative modality. This generality constitutes a focus of attention and interest for the author. According to Strong, it is the generality encompassed by medicalization that attracted several researchers, including himself, to the study of this process. This occurred because the conceptualization of this process would make it possible to frame in an overall picture smaller problems in scale, concrete research findings, and even looser ideas arising from readings and everyday experiences.

Based on his generalist perspective, Strong proposed to reformulate medicalization as a form of imperialism, which the author specifically calls the 'thesis of medical imperialism'. The critique of medicalization is thus understood in terms of a critique of medical imperialism. However, as can be seen from the title of his article, Strong's purpose is the critical introduction of a sociological kind of imperialism. That is why he presents his essay as controversial. According to Strong, the thesis of medical imperialism arose from the general sociological analysis of professional ambition and constituted influential developments in the sociologies of deviance and medicine. Strong does not neglect the merits of this thesis of medical imperialism, nor does he abandon the reflection upon the conditions for successful medicalization. However, he considers this thesis, this critique, "both exaggerated and self-serving" [115] (p. 199).

For Strong, the same type of analysis that underlies this thesis could be applied to sociology, providing, in its own programmatic synthesis,

> "a more satisfactory theory of professional change, one which explains the appeal of both conservatism and radicalism at different points in a profession's trajectory. Applying this to medical sociology, it is argued that current critiques of medical expansion, although containing much that is of value, are in some places misleading or exaggerated, for this young discipline and its ally, public health, have a vested interest in the diminution of the present form of the medical empire. Moreover, the social model of health which they themselves prefer is in some ways a better vehicle for medical imperialism than the much abused 'medical model'" [115] (p. 199).

This constitutes the reason why it can be said that Strong's perspective is, at the same time, a meta-sociological critique and a sociological meta-critique. In our view, his reformulation of the critique of medicalization as anti-imperialism, as a variety of imperialism critique, a kind of mirror effect of the critique of medicalization, is perhaps the highest point that the tension between medicine and the social sciences has reached. Furthermore, we believe that understanding the reformulation of the critique of medicalization as anti-imperialism is a *conditio sine qua non* so that, in further research, we can make intelligible

how this tension reaches a critical situation an even more critical point, in the present pandemic context.

Some authors believe that this reformulation is, in itself, greatly exaggerated. In the commentary tradition that has established itself around Strong's work, Peter Conrad will be largely responsible for recovering the idea first advanced by Zola in the frame of reference of the medicalization critique that medicalization cannot be explanatorily reduced to the thesis of professional imperialism.

Seeking to support this critique of critical criticism, Conrad and Joseph W. Schneider published a commentary on "Strong's Critique of the Thesis of Medical Imperialism" as early as 1980, in the same journal in which Strong had published his text one year before [154]. The theme was recovered in several texts by the same authors [155,156]. Conrad and Schneider recognize the value of Strong's positionings. Overall, they positively evaluate the idea of Strong's proposal of a reflexive analysis of medical sociology. They think, for instance, that the author rightly corrects oversimplified conceptions and exaggerated claims about medical imperialism. They also consider that Strong is quite right to point out that sociology is a profession and that, as such, it maintains its own interests. Conrad and Schneider believe, in particular, that the growing professional interest of sociologists in the medical field may well represent "the appeal of the social attractions and rewards" in this domain [154] (p. 76).

Despite this, Conrad and Schneider feel that Strong's approach has several serious shortcomings. Essentially, the authors argue that Strong has a narrow view of medicalization, missing the complexity of the concept and the perception of the various contexts of occurrence and study of the respective process. For both, the understanding of medicalization as imperialism is reductive and normative, and its sociological corollary is inconsistent. Such an understanding does not correspond to the concept of medicalization employed by several critics, such as Zola, thus blurring the diverse argumentative distinctions that follow the debates on medicalization. This is a reductive understanding because, resulting from Strong's own ethnographic field research on doctor–patient interaction, medicalization is thought of by this author only at the level of these interactions, leaving aside the conceptual and institutional levels and the political and definitional character of medicalization. This understanding is normative since it imputes to the concept of medicalization motives, a load of intentionality, which is not only not defended by critics such as Zola but which is very difficult to verify empirically, not seeming to be verified in Conrad and Schneider's own historical research on the medicalization of deviance. In this context, these authors suggest "to conceptualize the expansion of medical jurisdiction as *medicalization*, which is a more descriptive term" [154] (p. 75).

Considering the sociological corollary of the understanding of medicalization as imperialism also involves unverified intentionality, since the sociological profession cannot expand its potential jurisdiction in the same way as the medical profession, since it has no individual clients, has no direct prescriptions, nor can it provide the satisfaction of such a direct intervention, Conrad and Schneider further consider this corollary to be inconsistent because, while the analysis of medical imperialism focuses on the level of doctor-patient interaction, the analysis of sociological imperialism is only dealt with at the conceptual level. Ultimately, Conrad and Schneider consider this corollary irrelevant to medicalization thought. In our view, it is the opposite: the idea of sociological imperialism represents a step forward in the tensions between health and society to which we cannot be indifferent.

Despite the pertinence of Conrad and Schneider's critical response observations, a good part of the evaluation of Strong's arguments presented by these authors, provided with a comprehensive source of case studies in the context of medicalization critique, is nothing more than a corrective of short range. In addition to the major foci of criticism, Conrad and Schneider accuse Strong of grossly simplifying the attended difficulties and respective perspectives on them, of having been selective in his examples, of ignoring the then-recent literature on medicalization, of inventing problems that can be considered false, of underestimating modern medicine's technical achievements and overstating some con-

straining forces, namely that of the modern capitalist state. However, all these accusations are followed by notes of argumentative agreement. The variation is not of substance but of degree. Therefore, in our opinion, Conrad's and Schneider's statements, taken together, demonstrate Strong's creativity rather than the imminent failure of his argument.

Notwithstanding the recognition achieved in the meantime by Strong's formulation of the thesis of medical imperialism, and although several of the criticisms pointed out by Conrad and Schneider are legitimate, perfectly acceptable, and accurate, the substance of some of them were previously considered within the framework of the limitations presented by the author himself. The question will eventually be to ponder the extent to which Strong was coherent in recognizing his limitations; that is, if and when he overstepped the limits he recognized in his own work. For the sake of our argument, we must then rehearse his view once again.

6. The Professional Variety of the Negative Modality of Medicalization

The thesis of medical imperialism is expounded by Strong as a segment of a broader thesis of 'professional imperialism'. In Strong's view, this is a general thesis, applicable to all professions, revealed by the "general debunking of professional pretensions", particularly by the "general sociological analysis of professional ambition", and revealing special danger in the case of professions that accumulate more power [115] (p. 199).

The thesis of professional imperialism is summarized by the author through the exposition of a set of basic assumptions. There is an elementary tendency for handling social problems to be assigned to full-time professions and professionals. Certain professions monopolize the provision of certain solutions or services. This provisioning tends to control that service's nature and normative criteria. Such control tends, in turn, to expand beyond its original remit, redefining problems in other areas and discovering new problems whose solutions can only be provided by its professionals. This expansion is potentially indefinite. Moreover, any profession can give rise to such a process. This expansion will be articulated with the tendency to understand the etiology of social problems in individualistic terms, which obscures causality and depoliticizes social processes. In conjunction with the modern relevance of science, the professions most called for expansion are those that deal scientifically with the properties of individuals. The expansion of the domain of such professions will also be stimulated by the increase in demand from clients who have become addicted to prevention and treatment products. Ultimately, all problems identified, even when it comes to bodily harm, can be considered products of social forces, so disease prevention and treatment imply social change.

Strong argues that critics of medical imperialism share "a rough consensus" about its shape [115] (p. 200). However, he acknowledges and assumes several limitations of his study. First, he finds that his synthesis does not do justice to the diversity of views on imperialism. He admits Zola's criticism of intentionalism in the case of medical imperialism but considers that the very notion of imperialism does not embrace an intentionalist perspective. Furthermore, he finds that the notion of imperialism correctly captures the professional expansionary potential and the associated professional political threat. Second, Strong also believes that critics of medical imperialism do not agree on the nature of society. This implies that the notion of imperialism is inscribed in different causal and axiological schemes, examples being the studies of Vicente Navarro and those of Illich. Third, Strong clarifies that he will only address one segment of the medical imperialism thesis: the part Conrad and Schneider will understand as the medicalization level of doctor-patient interaction.

After clarification, Strong proceeded to the exposition of his 'sociological imperialism thesis' as a sociological version of the professional imperialism thesis and, in this condition, in his reading, rival of the medical imperialism thesis. As Strong says, "the thesis of professional imperialism cuts two ways" [115] (p. 205). He begins by arguing that most sociologists have been unreflexive about professional imperialism. Perhaps we can speak of a deficit of reflexivity in the sociological analysis of the medical profession: sociologists

accuse doctors of conditions that they themselves suffer without realizing it. In order to increase reflexivity, it would be necessary, in Strong's view, for the discipline to fold in on itself based on the analysis of the professions. The author applied the same perspective sociologists mobilize to study the medical profession to the sociological scope itself. He used the method of professional analysis in the theoretical framework of what he manages to be a theory of professional change. However, he considered that the thesis that sociology is a practicing profession in a narrow sense is not acceptable. It is, first and foremost, an academic discipline insofar as it has no individual clients and has resisted the usual processes of professionalization. Despite this, Strong defends that sociology may be seen as a profession in the sense that it does possess "most of the crucial traits by which we normally identify professional occupations" [115] (p. 202), namely, it seeks to serve humanity, it is supported by an academic body of knowledge, it maintains concerns regarding the practical application of such knowledge, it has clients although they are not individuals, but groups, such as governments, bureaucratic organizations, or representatives of less powerful groups, such as trade unions. It is in these terms that Strong understands sociology as a profession and 'practicing sociologists' as professionals.

He frames the application of the thesis of professional imperialism to sociology in the broader context of Alvin Gouldner's critical characterization of the history, social position, and ideological functions of modern sociology (also referring to the Marxist critiques of Martin Shaw and Martin Nicolaus). Gouldner considered sociology a product of the bourgeois social order, of modern interventionist capitalism, of the welfare state, and a means of legitimizing and maintaining it. In this context, sociology is a form of "mindless empiricism" and "atheoretical managerial" social science [115] (p. 201). Nevertheless, Strong believes that Gouldner and his fellow-critics analysis exaggerated the interdependence between capitalism and sociology.

From Strong's point of view, it is necessary to take into account, in general, some conditions of production of bourgeois sociology and, in particular, associated factors of analytical distortion specifically related to the sociological analysis of the medical profession. Strong talks about those conditions and these factors separately, but they are deeply articulated, so it is worth considering them in an integrated and conjoint way.

First, contemporary sociology lacks historical sensitivity, which contributes to devaluing and exaggerating present trends. Second, sociologists suffer from professional skepticism in the sense that there is great proximity between analysis and critical devaluation. Based on the ideas of Paul Halmos, Strong considers that this skepticism, in addition to conveying the idea that sociologists are incorruptible, supposedly generates the paradox that sociological criticism of the way society is organized allows sociologists to progress within this society. Third, the intellectual freedom that sociologists enjoy is superior to that of other academics. The articulation between the second and third elements allows us to perceive that, in this way, sociologists can more easily become great critics of the societies in which they live. Fourth, sociologists' professional status is neither passive nor disinterested; sociologists are part of the professional schema of ideological and technical competition. They are, to use Strong's quite liberal tone, "in the market-place" [115] (p. 202).

Strong argues that, like any other profession within bourgeois society, sociologists thus have imperial ambitions. In particular, they are not passive commentators on the medical profession, and sociological commentaries are not disinterested. While he recognizes that medicine now has a power that sociology does not have, Strong does think that sociology seeks to rival medicine. Note that, for the author, the point is not just what we call the deficit of reflexivity. The point is again a paradox: by criticizing the imperialism of other professions, sociologists advance their own empire. The lack of reflexivity of sociologists on professional imperialism turns into a danger of "unreflexive radicalism" [115] (p. 204).

Fifth, sociology has a sales appeal of its own, which leads sociologists to become involved in ambivalence. In a society where individualism is heavy, by not having individual clients, sociology is socially weakened because it depends on group clientele and, in addition, this clientele is divided between more powerful groups, such as rulers of

countries, and less powerful groups, such as the working class. This situation is inherently tense. Yet, sixth, sociology is never compromised by committing to the less powerful, given that sociologists belong to an elite class and occupy an advantageous structural position. Seventh, Strong does not let us forget that sociologists will never simply be medical students, for sociologists too will, in a certain context, be the patients of doctors (while, let us add, doctors will hardly be clients of sociologists).

Only after looking at the sociological discipline and profession in general, trying to show how it can represent the rival to medicine, did Strong consider the thesis of sociological imperialism in the context of the specific situation of medical sociology. He argues that medical sociology had a managerial role until the 1970s, but that since then, this has been changed thanks to the study of the history of the subdiscipline, attacks on empiricism, and criticism of administrative abuses and their political connotations, following the general sociological self-awareness that characterized the previous decade. However, Strong considers that these transformations only altered the phase of sociological imperialism, not having provided the necessary reflexivity. By critically understanding their establishment and constantly emphasizing the social and political nature of medicine, sociologists ask for more attention. However, they do it without giving up their subservience to the medical order. We may perhaps add that other sociologists, generally and independently, have referred reflexively and critically to some form of sociological imperialism [157].

Notwithstanding all the above conditions, Strong defends the validity of sociological ambitions and productions and that even the analysis of the medical profession is not mere hypocrisy, but that these ambitions and the thoughtless naivety on which they are based have made this analysis exaggerated. For Strong, this exaggeration constitutes a source of empirical selectivity and distortion, leading sociologists to ignore or distort evidence, especially if the evidence contradicts established views on medicine.

The author speaks of six particular kinds of distortion. The first distortion common among medical sociologists is the tendency for critiques of medical imperialism to be based on what Strong calls "the benefit of hindsight", and the second for these critiques to suffer from a lack of historical or anthropological awareness [115] (p. 205). The fourth distortion is a tendency to underestimate the success of modern medicine in technical terms. The fifth is the putative misrepresentation of capitalist control over medical imperialism. The sixth distortion is the trend to overstate patient addiction to medicine. Strong detects, commenting on this tendency, an assumption that deserves to be mentioned: as medicine is important to physicians and scholars, they assume that medicine should be equally important to others. This assumption can be particularly harmful in questioning patients in empirical sociological research, namely structuring interviews. "By focusing on what patients make of medical services", writes Strong, "they fail to set their comments in the wider context of patients' lives and thus often ascribe to them an unwarranted importance" [115] (p. 298). We purposely skip the third kind of distortion mentioned by Strong, leaving it for the end because it more directly concerns the argument of our article. This is the "tendency for sociologists to perceive the dispute as one *between* sociology and medicine itself" [115] (p. 205). The point that Strong seeks to underline in this case is that the generality that medicalization criticizes homogenizes a universe of disciplinary and sub-disciplinary diversity, forgetting that the expansion of medicine may vary in terms of interest, expertise, and ideology of medical specialties.

In addition to these distortions, Strong identifies factors embedded in the very position of medicine within the modern bourgeois society which serve to limit or restrict the threat of medical imperialism but which sociological exaggeration has obscured. The author mentions four factors: the capitalist financial system is not limited to positively financing the medical profession, it also constrains it; the medical community has limited the number of people entering the profession, which limits professional expansion; medicine, as understood by Strong, is an "applied science, a fundamentally pragmatic discipline" [115] (p. 209), so its professionalization is followed by scientific, technical and practical concerns, and doctors themselves have skeptical attitudes towards the medicalization of social

conditions such as alcoholism (see [158]); finally, the state granted doctors a monopoly of practice, but patients' behavior is protected by bourgeois freedoms.

As can be seen from the observations of Conrad and Schneider, an enterprise as creative and critical as Strong's naturally lends itself to much criticism. We could undoubtedly add a few more to the list. From the outset, we could speak of the weak argumentative foundation to support the idea of a sociological profession, which is essential for the rest of his analysis. In this context, when his entire perspective is so dependent on defending the professional character of a given activity and despite having Everett Hughes or Terence J. Johnson in his bibliographic references, the absence of a clear distinction within the sociological theory of professions of degrees of professionalization or concepts such as 'occupation' and 'profession' is quite questionable, either to undertake a social history or a historical sociology of medicine, or to adopt an analytical conception of sociology. This absence, among others, is due to a significant elemental flaw in Strong's approach. In our view, his mistake in the reconfiguration of the critique of medicalization as a critique of medical imperialism does not seem to be found in its substantive content. Instead, it lies in the profession-based approach dominant in the sociological study of health, illness, and medicine and with which Strong does not break but which develops to the limit of sociological contradiction. In this sense, Strong's mistake is also Conrad's mistake, but also Parsons's and Freidson's. The lack of understanding of imperialism in the field of health and sociology is not, in our view, found in the argumentative dispute between the authors but in the fact that sociological analysis is reduced in this context to the analysis of professions. This kind of reflexivity is not dispensable, but it is not enough.

7. Foucault, Social Constructivism, and the Anti-Realist-Positive Modality of Medicalization

Although Illich's work typifies for many authors a critical and skeptical approach to medicine, it is essential to underline that, on the one hand, as we have seen, criticism and skepticism regarding medicine are not new, nor is it restricted to the outside eyes of the medical tradition. It is also important to emphasize that, on the other hand, concepts such as professional dominance or iatrogenesis do not fully cover the innovation that skepticism has to deal with in our time. That is, the problems of medicine no longer concern the errors of the medical profession but the very scientific transformation and scientific specificity of medicine.

The scientific mutation, or scientificization process, of medicine has been perceived, analyzed, and scrutinized by researchers from different research subfields dedicated to the study of the HIMC. It has been articulated with other macro, sub, or complementary processes alongside the development processes of various sciences, laboratories, and industries, such as the molecularization of biology and the progressive formalization of medical decisions [159–164]. However, at the same time that in the scope of the study of the dynamics of professionalization, an erosion of the autonomy of the medical profession has been evidenced, mainly thanks to managerial policies and the corresponding quantitative reorganization of medical work and knowledge [165–171], on the side of the social sciences, there has been a generalized and profound change in the scale of analytical values. What, as we said initially, referring to the works of Lupton [5] and Berg and Mol [6], can be understood as remarkable convergences of contemporary epistemological transformations concerns, above all, convergence in an increasingly radical perspective of critique of the biomedical model.

It is a convergence between poststructuralism, phenomenology, sociology of knowledge, and sociology of science with a constructivist bent, especially from the relationship established between knowledge and power in Michel Foucault's work [5,16,17,172–178]. A number of authors in the post-war period found in this convergence a way to overcome the absence of a broad theory in the social study of health and medicine, and from there, they also defined their research topics. The more classical approaches of medical sociology and sociology of health, such as that of Freidson, had already absorbed elements of con-

structivism; they accepted without any exception the existence of social factors in the scope of health, illness, and medicine. However, as M. R. Bury highlights [178], the causal effect of these factors was restricted to the social sphere, and the distinction between illness and disease was accepted.

What is happening now is that the limit has been breached. There is, therefore, no constructivist turn but a constructivist radicalization. The theoretical centrality of these approaches reflects the epistemological centrality of social constructivism in diverse areas of the social sciences (see [179]). Such approaches allowed us to think about illness and disease beyond their supposed status as fixed physical realities, which is essential for social scientists. The ideas about illness and disease categories came to be seen as phenomena shaped by social experiences, shared cultural traditions, and changing frameworks of knowledge. However, instead of illness and disease being understood as invariable natural objects, what has alternatively been maintained is that they correspond to socially constructed evaluative concepts insofar as they can assume a plurality of social and cultural meanings, meanings that can be (and often are) variable in time and space. The scope of this constructivist approach was not limited to understanding the socio-cultural meanings underlying illness and the analysis of the variation of disease experiences. This type of analysis was also extended to scientific knowledge itself as it was developing in a specific political, economic, and technological context (see [180]). On the one hand, professional conceptions and categories of medical knowledge began to be equated as socially situated symbolic systems. On the other hand, it became increasingly challenging to disarticulate these two dimensions (disease experience and medical knowledge) since the way of managing and giving meaning to the disease is carried out within the framework of biomedical understandings that, by giving existence to certain conditions, organize experiences into specific diagnose categories [181,182].

These approaches allowed many areas to question the conceptual limits of the disciplines that study health and medicine. What remains to be seen is that the progressive approach of medicine in relation to the natural sciences has homogenized culturally, socially, and politically what we understand by health, illness, and medicine and, with that, also how we relate to medical knowledge, erasing a series of tensions inherent to the intrinsic diversity of health-related and medical phenomena. There were, in particular, internal disciplinary breaks. For example, in the case of medical anthropology, the application of the concept of ethnomedicine to biomedicine [183] and a move away from the notions of medical systems and medical pluralism in the name of the notion of syncretism [184]. In the context of the history of medicine and the sociology of health, an attempt is made, for example, to understand the type of historical orientation that has governed the reconstruction of the biomedical model [185].

The recognition of these achievements becomes more debatable and paradoxical when the development of such questions, based on a relativist epistemological orientation and an ontological orientation of an anti-realist type, translates into frameworks that reiterate reductive interpretations of medical knowledge, actively committed to rejecting any idea of autonomy from the natural world. What tends to prevail is the denial of the ontological reality of the natural world, which results in the basic postulate, when applied to medical knowledge, that illness and disease categories do not necessarily correspond to natural phenomena. These are, on the contrary, conceived either as the result of scientific consensuses essential to produce legitimate knowledge or (in their most relativistic version) as the expression of fabrications and discursive constructs oriented towards the dissemination of a disciplinary power structurally rooted in the modern world. In the sociological field, following the previously mentioned thematic specialization around the social dimensions of illness, there is a constructivist worsening that is well captured by the idea of a medicalization nominalist orientation [186] and by the expression 'biophobia' [187,188]. We can capture this idea well if we look at Foucault's influence.

In Lupton's chapter previously mentioned, the author introduces and develops the interpretative thesis that there is no explicit and systematic Foucauldian adherence to the

critique of medicalization but that it is possible to add from the study of medicine in a Foucauldian perspective a specific perspective on medicalization. Lupton even considers that Foucault and his readers agree with the idea that "medicine is a dominant institution that in Western societies has come to play an increasingly important role in everyday life, shaping the ways that we think about and live our bodies" [113] (p. 106). However, in his words, "the Foucauldian perspective articulates a more complex notion of the role played by medicine in contemporary Western societies" [113] (p. 94).

The interpretation that Foucault did not define his own version of the critique of medicalization should not –let us underline carefully – equate to the interpretation that the author did not address this concept. In fact, the distinction between his understanding of the medicalization process and that of the repressive-negative version, namely that of Illich, was very well captured by Foucault himself in a series of conferences held in 1974 as part of the Social Medicine course at the Instituto de Medicina Social at the Biomedical Center of the State University of Rio de Janeiro and later published, between 1974 and 1978, in article form in the journal *Educación Médica y Salud*, under the responsibility of the Pan American Health Organization [159].

We know since *Naissance de la clinique: une archéologie du regard médical*, published in 1963, that there were several areas of disease distribution in addition to the one that concerns the human body and several corresponding epistemological configurations of medicine [75]. One of Foucault's fundamental theses is that the emergence of pathological anatomy and its development at the end of the 18th century, particularly with Marie F. X. Bichat and his disciples, led to a reconfiguration of medical perception; clinical experience came to concern an anatomo-clinical gaze. The body, with its tissues and organs, becomes the space of clinical experience, symptomatic medicine recedes, and the analysis of the body becomes crucial in the pathological process. Foucault also did not forget that this transformation follows a process of secularization, in which medical intervention replaces the religious figure of salvation insofar as it confronts humanity with its finitude. We find this notion in several passages of *Naissance de la clinique*.

The important aspect that Foucault adds and clarifies in the 1974 conferences is that the critique of medicine itself is not new, that the novelty is, with the scientificization of medicine, it leaves the regime of error. According to Foucault, it was not necessary to wait for the critics of medicine in the 20th century to know that medicine has negative effects. What has changed is the configuration of these effects due to its development as a science:

> "It was not necessary to wait for Illich or for the anti-medical agents to know that one of the properties and one of the capabilities of medicine is to kill. Medicine kills, it has always killed, and we have always been aware of that. The important thing is that until recent times the negative effects of medicine have been registered in the register of medical ignorance. Medicine killed because of the physician's ignorance or because medicine itself was ignorant; it was not a true science but just a rhapsody of ill-founded, ill-established, and verified knowledge. The harmfulness of medicine was evaluated in proportion to its unscientificity. However, what has emerged since the beginning of the 20th century is the fact that medicine can be dangerous, not insofar as it is ignorant and false, but insofar as it constitutes a science" [159] (pp. 21–22).

Let us return, once again, to Lupton's unlimited text to observe the synthesis she makes of a Foucauldian perspective on medicalization from the comparison between what she understands as the orthodox medicalization critique and the Foucauldian commentaries on scientific medicine. We have already mentioned the brief similarity. Now it is time to look at the significant differences. According to Lupton, Foucault's work challenges the prevailing conception among critics of medicalization on power and medical knowledge.

This challenge can be understood from three points. The first concerns his conception of power, which is more complex than in the case of repressive-negative critics. The Foucauldian conception of power has, in turn, three basic characteristics. Power, in Foucault, is relational, dispersed, productive, or positive. That it is relational means that it "is not a

possession of particular social groups", it is "a strategy which is invested in and transmitted through all social groups", it is a relation [113] (p. 99). The physician is not a figure of dominance but, as Lupton writes, quoting Foucault, 'links in a set of power relations'. Therefore, contrary to what the other critics propose, Foucauldians consider that it is not possible to take power away from doctors and pass it on to patients. The demedicalization strategy would thus be contradictory.

Power is dispersed in the sense that it is unintentional, lacking a central political rationale. In this way, although they recognize a margin for medical dominance and a role for the state in the regulation of medical activity, from the point of view of Foucault and his followers, the intentional load of the notion of medicine is so small that it reaches such heterogeneity that physician's exercise is placed far beyond the clinic and the hospital, including workplaces, schools, supermarkets. This perspective is profoundly incompatible with the idea of medicalization as professional dominance.

Finally, power is productive or positive; it is not negative, it is not repressive. According to Lupton, from the Foucauldian perspective, in the medical encounter, disciplinary power is exercised not through direct coercion or violence but through knowledge. According to Lupton, Foucault is very close in this respect to social constructivism. From both points of view, medical knowledge is not seen as simply factual but as a belief system shaped by power relations. From this, as Lupton rightly points out, the other critics of medicalization would not disagree. The point is that Foucault and his followers go further in that, as already said, they adopt an anti-realist ontological and relativist epistemological point of view. Furthermore, this is the most distinctive aspect of this second modality of medicalization. For Foucault and his followers, the body does not exist outside of power relations and forms of knowledge. The body is, in a strict sense that annihilates biology, a socio-discursive construction. Medical knowledge and practice are not representations of the body but agents that actively participate in its construction. Once again, the orthodox solution of demedicalization could only sound paradoxical, as it would imply more involvement in medical knowledge and thus more medicalization. Therefore, the concept of demedicalization is incompatible with this modality of medicalization.

Lupton presents several criticisms of the Foucauldian perspective, but her presentation largely boils down to difficulties created either by internal inconsistencies in Foucault's work or the effects of the reception of his work, with greater attention given to early works than to later ones. The way that Lupton solves these problems lies in a phenomenological reorientation of Foucault's latest works. This does not seem to us to be the most pertinent point.

The most pertinent point seems to be to understand this change in the context of the epistemological transformation that, from one end to the other, the social sciences of health have been going through. In one of the last revisits to the thesis of sociological imperialism as formulated by Strong, Simon J. Williams sought to understand which aspects of this thesis can be retained, taking into account the criticism it was subjected to and in the light of the most recent developments in medicine, of medicalization and beyond the very scope of the sociology of health [189]. Williams' text interests us because it underlines the problematic epistemological and ontological duplicity that follows the radicalization of constructivism.

Williams accepts that medicine is not homogeneous and that the expansion of the medical empire cannot be an undisputed assumption. Echoing Strong directly, he then suggests that the central issue has to do with limits and comes to defend the limits of medicalization and the limits of sociological critique. Looking at the over-medicalization and demedicalization debates, Williams follows up on Conrad by emphasizing the bidirectional character of the medicalization process and the levels and degrees of medicalization – a theme that we will approach in the following section. However, he promotes an update of Strong's critique within the framework of the debates on the social construction of medical knowledge undertaken by Michael Bury, Malcolm Nicolson, and Cathleen McLaughlin

and the development of the Foucauldian scholarship critiques of medicine, the body, and disease.

Following the perspective of Andrew Sayer, Williams considers that the social constructivism extended by Foucault does not solve the fundamental problem that constructivism initially proposed in the scope of the study of the body, health, and illness: the problem of strong essentialism, biological reductionism, and determinism. What it does is invert the solution: instead of being strictly biophysical entities, body, health, and illness become mere social fabrications, specifically discursive entities. Following Ian Craib, Williams declares that this reversal is a paradoxical form of sociologism, as it ends up reducing sociological explanation itself to discursive determination. Without abandoning the limitation of a strictly medical vision, which gains relevance with the development of the new genetics and evolutionary psychology, Williams then suggests that the limits suggested by Strong also encompass the limitation of social constructivism and Foucauldian scholarship.

For Williams, all these limitations must converge to accept the partiality of all forms of knowledge, to recognize the importance of the diverse contributions of knowledge according to the intellectual division of labor, to understand an ontologically and epistemologically complex world, to recognize the heterogeneity of medical and sociological perspectives, and not to reject the relevance of medicine to our quality of life. In short, as we have been defending from the study of tensions between the HIMC and society, it is necessary to redirect our gaze, clinical or not, to the diversity of forms of knowledge.

8. Reassessing the Concept of Medicalization in a Technoscientific Society and Therapy Culture

As we already stated, the concept of medicalization was addressed and developed by several authors in a wide range of contexts. Since the emergence of the concept and its subsequent theoretical developments, many conceptual debates have taken place, and much empirical research has been developed, which has contributed to the level of sophistication of the social analyses built upon this concept. From them, we obtain important heuristic devices for the clarification of several dynamics regarding the way medical perspectives have become constitutive of the ways of thinking and knowing health, as well as in the way of organizing experiences and complaints according to diagnostic categories. Therefore, while the effective processes of medicalization have been covering more areas of life, the critique of medicalization has also been widening. There are undoubtedly deep theoretical nuances in the authors' perspectives. However, there are other changes that should be considered. As Zorzanelli, Ortega, and Bezerra Júnior say, "the relevance and actuality of the concept of medicalization is demonstrated by the reach that the theme has been acquiring in publications in the field of human and social sciences in the last decades" [112] (p. 1860).

In the case of the line of argument that we seek to develop here, the effort of theoretical discussion does not imply that the analytical merits of a concept that has been systematically mobilized and operationalized over practically five decades are not recognized. The census exercises already carried out, or the critical reassessment carried out by some of its main promoters, are indicative not only of the multiple contributions that have been developed but also of the very mutations that the concept has known, which is in itself denoting its elasticity, as well as the adaptive nature of the processes that this concept seeks to cover. A characteristic that has always been notorious is how this critical view has been branching out into different problem areas, forming a well-defined diatribe regarding the role of medicine. Within the framework of this development, many authors and positions were deepening the scope of the concept by means of new lines of exploration, which contributed to the gradual consolidation of discussions aimed at clarifying the complex, plural, adaptive, and contested character of medicalization processes, but also noticing that they started to assume new facets and configurations.

Gradually, it has become necessary to recognize that medicalization can have multiple dimensions and levels of analysis (see [190]). First of all, one must recognize the drastic

expansion of the segments of life that were medicalized and turned into a terrain or object, an empirical field. Abortion, political activism, AIDS, alcoholism, child abuse, hyperactivity, infant death syndrome, aging, poisoning, menopause, premenstrual syndrome, race, pregnancy, masturbation, sexual orientation, sexual gender, obesity, compulsive buying, disability, breastfeeding, drug consumption, childbirth, shyness, sleep, sadness, and even death and normality. These are some topics that have been studied within the scope of medicalization studies.

Conrad, initially in collaboration with Joseph W. Schneider, is one of the main authors responsible for imagining medicalization as a complex process and, especially, for developing the corresponding idea that medicalization processes occur and can be studied in various contexts [154,155]. In their critique of Strong, the authors define for the first time that medicalization can occur on the conceptual, the institutional, and the doctor–patient interaction levels. Precisely in view of some of these main changes, Conrad concedes that medicalization processes are bidirectional and partial. He does not fail to emphasize that despite the existence of 'shifting engines' of medicalization grounded in commercial interests, this dynamic persists rather than contradicts, as multiple possibilities for new medical categories may arise [191].

Moreover, Conrad himself recognizes that medicalization does not necessarily require a professional anchorage but rather an acceptance, on the part of various actors, of medical knowledge [156]. As he himself maintains, "an entity that is regarded as an illness or disease is not ipso facto a medical problem; rather, it needs to become defined as one" [192] (pp. 5–6). Conrad changed his analytical emphasis and shifted it from fundamentally jurisdictional aspects to definitional aspects, the process by which social problems become medical problems. This vision gives a more constructivist content to the concept [193]. Medicalization came to be understood as a process of definition. In other words, a process that results in the conversion of social problems into medical problems, which in practice means that they are defined in medical terms, described in medical language, understood in a medical frame of reference, and treated or managed through medical interventions [156,192].

Additionally, at the same time that the meaning changes, the process starts to welcome more actors and to be comprehended in a sense that no longer fits the professional perspective. "This is a sociocultural process", as Conrad puts it, "that may or may not involve the medical profession, lead to medical social control or medical treatment, or be the result of intentional expansion by the medical profession" [156] (p. 211).

Thus, recognition that there are new actors and new dynamics that play an important role in the reconfiguration of medicalization gains strength. With the end of the assumption of inexorable professional dominance, namely through the expansion of critical and skeptical attitudes towards professional authority (medicine becoming linked to greater public scrutiny), as well as a growing involvement of governments in funding and regulation [191,194], the narrative of medical imperialism, as well as the assumption of the docility of individuals, fails. It is becoming evident that the public is actively searching for medicalization to legitimize existential experiences and problems [195]. This shows that medicalization must be understood as a form of collective action where patients and other lay actors can be active collaborators. They are committed to the medicalization of their problems, especially when they mobilize to exert pressure, or even demand (as with contested diseases), medical categories for their conditions, even when physicians express reluctance to do so [171,196].

Equally relevant is the fact that more than the simple bidirectional nature of these processes, medicalization and demedicalization can, in their articulation, configure continuous processes in the sense of occurring simultaneously [190,197]. It follows that they should not be viewed as rigid categories that are limited to being present or absent in each context. On the contrary, they are processes referring to mutable possibilities of increase or decrease, although it is still significant that the analysis tends to be more systematically inattentive to demedicalization. This can be interpreted, as Drew Halfmann maintains, as a reflection of

the conceptual weakness of the literature on medicalization in reifying the idea that one process will be common and the other rare [190] (p. 187).

Other authors attribute meaning to the contestation of medicalization, assuming it as the expression of dynamics strongly articulated to a societal context marked by a more significant critical questioning that takes shape in scrutiny fed by increasing levels of social reflexivity and a keener awareness of the risks and limitations of expert approaches [198].

Thereby, the typical approach of the 1970s of medical power criticism changed, opening space for new approaches and more oriented towards analyzing other dynamics and other actors outside the professional field of medicine. However, the resonances of the agonistic positions that we have been emphasizing are still in the air. Especially when underlying the criticisms of medicine, there still seems to be resonances suggestive of the permanence of a vision that presumes the existence of a professional monopoly with normalizing and regulatory ramifications in the production of health. Even though, in the case of Strong's perspective, it is important to bear in mind the vital point that criticisms of medical expansion have often translated into exaggerated and disproportionate analyzes of medicalization, especially when the emphasis of its conceptualization made it equivalent to a ubiquitous process based on an inexorable expansionist tendency and, as such, denoting the increasing colonization of multiple spheres of human life by medical imperialism.

All the new redefinition was responsible for considerably enlarging and generalizing the concept, but also for the emergence of criticism or reassessment readings. In recent decades, the very concept of medicalization has begun to be viewed with some suspicion, as we have already mentioned. In a recent article, Joan Busfield gathers and organizes the different types of criticism on the concept of medicalization itself and seeks to challenge them [193]. The first type of criticism stemmed from the putative confusion between medicalization and medical imperialism. According to Busfield, reflecting Illich's emphasis on industrialization as the cause of medicalization, Strong and also Simon J. Williams confused the two concepts. Although industrialization can be considered as a preponderant factor of medicalization, the latter, as a process, is not reduced to it as a cause. Thanks to this confusion, the critique of medicalization came to be seen as an exaggerated form of criticism, namely for having a passive conception of the patient and being interested in defense of public health as a branch of interest in medical sociology. Medical imperialism thus gives rise to sociological imperialism.

The second type of critique, again reflecting Illich's perspective, assumes that the critique of medicalization is a total critique of medicine. This is what supposedly happened with Nikolas Rose, who, based on such an assumption, considered that the very concept of medicalization is nothing more than a cliché of social criticism, not recognizing any explanatory power. According to Busfield, there are several formulations and uses of the concept of medicalization. Although in Illich, we can find the insinuation of a generalized attack on medicine, Busfield finds two reasons for not adopting such a comprehensive concept of medicalization, at least as a starting point. First, the criticism of medicalization is usually based on studies of 'specific instances of medicalization', which are not even medical specialties, but particular problems. Second, to the extent that critics of medicalization recognize the potential and benefits of medical action (even in complex fields such as sexual and reproductive health). For Busfield, the central aspect of the value of medicine resides in the ability to articulate description, explanation, and criticism. This assessment is tied to what we call the repressive-negative modality of medicalization since this point would no longer be verified in the case of the other modality.

In fact, in 1985, in consultation at the Pennsylvania State University, Illich argued that, after medicine had monopolized the social construction of the body and, in the 1960s, the medical profession had become prominent in this regard, from the 1970s, the symbolic character of health care changed [199]. Medicine continued to play a role in the sociogenesis of our bodies, but its importance was reduced. According to Illich, a new epistemological matrix emerged in which it is the pursuit of a healthy body that becomes pathogenic and no longer needs medical intervention. Medicine continues to influence the way the body is

perceived, but medical theories and concepts are so publicly questioned that the medical system loses the ability—to use Illich's terms—to 'engender a body'. Perhaps we can add that, from a critical but realistic point of view, what is relevant from the 1980s onwards can no longer be the loss of the social agency of medicine but a strong contrast between this loss and the biotechnological conquest of agency in the artificial construction of bodies.

The third criticism of the concept of medicalization, according to Busfield, concerns attempts to replace this concept with others. An example can be found in the defense by Adele E. Clarke, Laura Mamo, Jennifer Ruth Fosket, Jennifer R. Fishman, and Janet K. Shim of the thesis that, in the 1980s, medicalization was replaced by a more complex process of biomedicalization, resulting from major political, economic, and technological changes. In Busfield's view, this new concept's complexity does not imply the rejection of the first but one of the paths for its development. Another attempt at replacement was carried out by John Abraham, who proposed the concept of pharmaceuticalization, emphasizing not only the dimension of drug therapy as a response to medicalization but also the expansion of the pharmaceutical industry. In this case, the author himself, maintaining some doubts, assumes that the concept of medicalization can subsume the other.

Busfield defended that the concept of medicalization retains its relevance. In order to justify it, she exposed two fundamental reasons. The first is that this concept identifies a process that is still taking place, making it possible to explore new factors in the development of known instances of medicalization or even to point out new domains of medicalization. The second reason given by Busfield to justify the relevance of the concept of medicalization is that it refers to the social, political, and economic causes and consequences of the changes considered in direct relation to the transformation of medicine.

What we argue is that the reappraisal of the analytical merits of medicalization needs to be considered within a framework of great articulation with a variety of social processes since the very limited focus around medicine can become reductive or even reify a reality that has become more pulverized in terms of protagonists and bundles of causality. From this point of view, it is important to integrate several other related concepts that denote new and differentiated articulations that constitute medicalization itself. This means that it is necessary to improve reading grids that are porous in the face of different transformative dynamics with an impact on ways of thinking about health and medicine in society. Whether these dynamics go through the recognition of the importance of biotechnological innovations that are at the base of the proliferation of biomedical solutions for the maintenance, improvement, or optimization of health, condensed in the concept of biomedicalization [200]; by considering the role of the pharmaceutical industry in the 'corporate construction of disease' across borders, via marketing, of treatable conditions to sell medical solutions with debatable clinical relevance, condensed in the concept of disease mongering (see, e.g., [201]); by, as the brand new concept of camization points out, subjecting problems that have become medical into perceptible and treatable health problems within the scope of CAM with the respective attempts to encroach upon mainstream healthcare [202]; or by the increasingly significant importance of pharmaceuticalization process, that is, in the transformation of human conditions into pharmacological issues that can be treated or improved [203].

In the latter case, and despite the fact that there are different assessments regarding the analytical importance of this concept, the realization of the relevance of the role of the pharmaceutical industry seems increasingly unavoidable. Not just because the impacts of the growing pharmacological expansion constitute one of the main driving forces (more than medicine itself) of the medicalization of contemporary societies [204], but also because this process is defined and manifested through two aspects of great relevance. First, by the generalization of the use of drugs to an increasingly broad spectrum of aspects outside the field of pathology. Second, by the development of new categories of need for medical and drug consumption, as a result of the pharmacological innovation itself.

More than just a concept derived from medicalization that would always depend on some degree of medical legitimation, pharmaceuticalization can effectively grow without

the expansion of medicalization, as it happens in the context of multiple social uses of medicines based on very different investment logics and oriented towards purposes that do not require the precedence of their medicalization as clinical conditions, being, consequently, refractory to the expert supervision of medicine. This is clearly the case, for example, of the pharmaceuticalization of daily life in that medicines, instrumentalized for the realization of a set of personal and social aspirations, are used to improve the quality of life in spheres of bodily hedonism such as sexual and aesthetic self-fulfillment [205], or for the improvement of several other issues related with lifestyle [206,207].

Equally illustrative of these new logics of pharmaceuticalization is the non-medical use of drugs for recreational ends, namely in university contexts by young people [208,209], the use of pharmacological resources to customize or manage sleep [210,211], chronobiological optimization interventions to address circadian disruptions resulting from the diverse impact of life rhythms [212], the use of pharmacological resources for enhancement purposes [213,214], or the consumption of medication for performance management and, therefore, human conditions that are not medicalized [215–219].

In this last case, what the empirical evidence highlights is precisely the autonomy of pharmaceuticalization in relation to the sphere of medical authority since the relationship with therapeutic resources is guided by the logic of the management of the social imperatives of everyday life. By means of a research project on the performance consumption of the young population in Portugal, it was found that therapeutic investments are developed not so much in the logic of overcoming the norm but in achieving this norm more quickly or with less effort [215,216,219]. This means that the imperatives of performativity and the expectations of response to its management are shaped by the pharmacological solutions available on the market, a circumstance that configures what can be called the 'therapeuticization of everyday life' [216]. That is, the use of a technology designed for therapeutic use but which also serves non-therapeutic purposes, replacing or gaining ascendancy over other types of non-drug investments, such as diet, sport, sleep, or meditation [219].

Looking at these examples collected from empirical research, the position of Simon J. Williams, Catherine Coveney, and Jonathan Gabe [220] gains greater consistency regarding the importance of analytical articulations and the variable relationships between these concepts. These interactions introduce a much more productive potential for analysis than if we perpetuate a look strictly focused on medical definitions or their ineluctable expansion. It is clear that the conceptual trajectory of medicalization configures an open narrative, not only for a theoretical reason but also given the heterogeneity and ambiguities of the empirical world.

9. Goodbye, Social Control: The Knowledge-Based Approach to Medicalization

The development of tensions accumulated in the critique of medicalization results from the development of the analysis of the medical profession as it has developed in the sociological literature, slipping towards the analysis of the sociological profession and being followed by the foundational instability of the sociology of health. However, while the object of this analysis is of a professional nature, non-linear developments of medical and sociological concepts emerge from it, including basic notions about what is meant by medicine and social science, especially sociology. This is emphasized by Conrad's and Schneider's distinction between levels of medicalization, especially their consideration of a specifically conceptual level. The same is also partially signaled when Conrad and Schneider accused Strong's version of sociological imperialism of inconsistency. It is inconsistent because it treats the sociological realm in conceptual terms while it treats medical imperialism from the level of doctor–patient interaction. Conrad and Schneider believed that Strong's concern with biology had to do with the author not having gone much beyond the doctor–patient interaction level of medicalization, but it can also be understood as naturalization of medicine resulting from a professional analysis that by default accepts the biomedical model that dominates the present development of the profession of medicine.

The affirmation of the theoretical relevance of the sociology of health remains profoundly current, perhaps more current than ever. However, ironically, we will not be able to understand its true scope if we do not consider the impasses that the sociological theorization of health, illness, and medicine has been going through. One of them is, without a doubt, that the professional perspective has become dominant. The evaluation of the knowledge dimension is not foreign to medicalization studies, but it was largely subsumed in the analysis of the professions. In order to understand the scope of the theoretical relevance of the sociology of health and to understand all this accumulation of tensions and consequent instabilities, it seems necessary to replace, or at least supplement, the profession-based approach. The fundamental reasons for doing so and some of its theoretical–empirical effects deserve careful attention. A recent article in which Tiago Correia proposes his version of the 'knowledge-based approach to medicalization', or 'knowledge-based critique of medicalization', actually coining those expressions, constitutes an important starting point for this [221]. Regarding the concept of medicalization, his perspective involves considering both theoretical and empirical scopes of analysis, giving special attention from the outset and stressing the importance in conclusive terms of the theoretical scope of medicalization.

Correia's perspective is a kind of non-constructivist off-shot of the constructivist development of medicalization studies. It is based on what we might call 'epistemological pluralism of medicine'. This point of view, as we interpret Correia's words, is explored by the author according to different argumentative frameworks throughout his text. It stems from a set of notions we think we can summarize in the following terms. First, the notion of the cognitive and cultural variability of medicine, exposed by the author according to the idea that the problems categorized as medical are not exclusive to Western professionalized medicine. Second, a methodological notion that follows this variability: if this form of medicine does not have this exclusivity, those problems are not, and cannot be understood, on the strictly biological or physiological infrastructure that underlies the medical knowledge of such a form of medicine.

From this rationale derives the broader consideration that a knowledge-based approach must appreciate different branches of medical knowledge. Regarding the concept of medicalization in particular, this means that a framework is needed that expands the medical categorization of problems to include "all forms of medical knowledge in a global society" [221] (p. 1), "irrespective of the political or scientific status of these branches in society" [221] (p. 2).

Correia delved into the field of medical ontology via the hermeneutical philosophy of Hans-Georg Gadamer to assess two underlying features of clinicians' praxis that have remained unchanged in the history of medicine. He did not do so to abandon the legitimacy of medical knowledge but to broaden the scope of its foundation regardless of empirical manifestations and empirical observations on medicine, namely beyond the institutionalized scientific foundation of biomedicine. As a reader of *Über die Verborgenheit der Gesundheit*, Correia refers to the scope of praxis as the first feature, in the sense that medical decisions are intrinsically contingency-dependent, or discretionary, and correspondingly only partially controllable. The second feature mentioned is that, despite the drastic variability in the meaning of the categories of health and disease and health care systems, the aim of medical practice concerns ordered explanations and judgment of what is understood by health and illness and interventions with the purpose of curing or treating. Correia believes that, considering the stability of those two core features of medicine's ontology, it is possible to establish a stable correspondent concept of medicine, which theoretically subsumes a diversity of practices, influences, and disputes among the different branches of knowledge, including non-scientific-natural or even non-scientific (including magical) knowledge and unregulated medical knowledge.

This plural opening enables Correia to question the dominant sociological perspective on medicine and medical knowledge and its expression in the very critique of medicalization. His drawing on hermeneutic philosophy allows us to question the "empirical-based

view of medicine and medical boundaries" [221] (p. 6). For Correia, propositions on medicalization, demedicalization, or remedicalization have as their basic condition the clarification of what is meant by medicine. Without necessarily opposing the hypotheses of biomedicalization and camization, it cuts with the underlying definition of medicalization, or, better still, with the definition of medicine underlying this underlying definition of medicalization. As Correia rightly argues, such definitions result from the effects of the profession-based approach dominant in medicalization critique. By focusing on the process of professionalization of medicine at the same time as biomedical knowledge gained relevance in social life, this approach accepted and reproduced the medical boundaries and definitions from the biomedical model. Just as the development of biomedicine excluded other branches of knowledge from the medical domain, so too would medicalization be overlapped by biomedical knowledge. Therefore, the sociological study of health, illness, and medicine would have adopted a reductive notion of medicine and medical knowledge, not only leaving out other forms of knowledge but also forgetting forms that, as Correia emphasizes, can be forces of medicalization. This is how Correia's proposal involves replacing the dominant profession-based approach with a knowledge-based approach.

Added to these notions is the consideration that adherence to medical truth does not depend only on this type of knowledge but on the extension of what Freidson called a 'lay reference' and on the institutionalization of social control itself. The epistemological pluralism of medicine on which Correia's knowledge-based approach is endured was then followed by a fundamental sociological argument around this last question of control. Following the discussions by Joan Busfield, Simon J. Williams, Catherine Coveney, and Jonathan Gabe on Conrad's concern with the definition of medicalization, Correia sought to save the critique of medicalization from the main criticism it has been subject to by establishing a "more analytical neutral [concept] in relation to different players and different forms of medical knowledge" [221] (p. 3), analytical neutral meaning less normative. The author himself recognized that with a knowledge-based approach, considering that medicine comprises different branches of knowledge but maintains ontological traits, it is possible not only upstream to separate the theoretical scope of medicalization from empirical observations but also downstream to operationalize with more accuracy the concept to be applied in the scope of comparative empirical research, allowing to critically explore its variations, namely clarifying the link to medical knowledge of degrees of social control, controlling players and respective procedures. In a way, our attempt to systematize modalities of medicalization is the result of the same type of ideas. Correia's considerations about social control allow us to take a step forward.

Correia reassessed the little-questioned link between medicalization and social control, taking into account, in our view quite correctly, in contrast not only with the tradition of medicalization critique but also with a good part of the naivety that governs current biopolitical critics of medicalization, that there is no a direct link between the two. The author emphasizes that he does not disagree with Conrad's conceptualization of medicalization as making things medical. Going further than Conrad, who had come to accept that medicalization precedes medical social control, Correia argues that, insofar as medicine and social control "stem from analytically independent dimensions" [221] (p. 7), medicalization is independent of the institutionalization of social control, that it does not presuppose social control and that social control may even precede medicalization.

As Correia argues, the branches of medical knowledge are a specific constitutive part of the medical realm. The institutionalization of control over societies is not isolatedly related to this knowledge. Contrary to what a Foucauldian vision implies, this control is not immanent. Drawing on works in the history and sociology of science and medicine, Correia has convincingly tried to argue that it depends on specific social and political contexts in which different players call upon medical knowledge and practitioners themselves engage in disputes over clients and state legitimacy. Finally, medical knowledge does not necessarily create disputes for social control but becomes creatively involved in these disputes.

In the Western social and political context, the link between medicalization and social control is obvious, but it is also there, according to Correia's perspective, that it is most easily inverted. The author argues that, with the process of the professionalization of medicine, thanks to the development of the biomedical field within the framework of the various branches of medical knowledge, it is possible to observe that several forms of medical social control took place before the consolidation of Western medicalization on a large scale. Relying on works such as those of Foucault, Freidson, Porter, David Armstrong, and Deborah Lupton, Correia argues that the first forms of medical-type social control occurred in the late 17th century in the context of state processes of normalization, normativization, and moralization of the human body, whereas disputes among different forms of medical knowledge only had a formal outcome in the 19th and 20th centuries. Reading George Weisz's work on medical specialization, Correia also warns of the cultural variability of these forms according to state integration. In short, in his words:

> "What these arguments highlight is that biological medicine only institutionalized medical social control (the process usually referred to as the medicalization of society) after having successfully monopolized the truths of the medical field, thereby becoming a profession. Therefore, medical social control emerged before the medical profession actually existed as such.
>
> Therefore, what happened in Europe at the turn of the nineteenth to the twentieth century was not the rise of medicalization of society as one can assume by the overlap between medicalization and biological knowledge. Rather, it was the comprehensive institutionalization of medical social control through the professionalization of medicine (Porter, 1999). Medicalized conditions and problems existed before and will continue to exist irrespective of the degree and scope of medical control in societies." [221] (p. 5).

What the knowledge-based approach ends up demonstrating is that there is a wide overlap between the profession-based approach and social control on medicalization discourse. The rupture with the profession-based approach is, accordingly, at the same time, a rupture not only with a dominant mode of knowledge but also a blow to the normative Western and professionalized notion of medicalization. What results from this is the realization that medicine should not be confused with biomedicine since the influence of the former actually precedes the historical context of modernity and the cultural space of the West that made the latter possible. These departures enable us to pluralize the concept of medicalization definitively. There is no 'medicalization of society' but several medicalizations which follow cognitive, historical, cultural, social, and political variability. Correia seeks to demonstrate from this opening that, in the Western context, it will be possible to observe that processes such as biomedicalization and camization are not alternatives to medicalization but different forms of it. Likewise, it can be seen that certain demedicalization processes are not generic but specific in relation to forms of biomedicalization. Outside the framework of the development of biomedicine in Western countries, the same view allows arguing that the link between medicalization and social control is not so direct, with medicalization taking place without the institutionalization of biomedical control.

Correia's attempt to understand the epistemological complexity of medical knowledge, substitute a profession-based approach for a knowledge-based approach, and to correct the issue of social control within the critique of medicalization by broadening the meanings of this concept, seems accurate to us but incomplete. We consider it right because it conceptualizes in an integrated way the target difficulties that seem crucial, in the sense that these are the difficulties that have prevented a better understanding of health, illness, and medicine in society. However, we believe that it is an incomplete adventure for three reasons. The first, and for us the most important, is that it is not based on a typology of knowledge. We do not believe that the focus should be exclusively on medical knowledge but on the relations of this type of knowledge with other forms of knowledge, namely social knowledge and knowledge produced within the social sciences. Second: adopting

the hermeneutic perspective of medicine already implies, in the field of theory, accepting a certain image of medicine, which means that Correia's approach may contradict the pluralism on which it seeks to be based. It is necessary, in this respect, to take a step back and look for an approach that, in the name of pluralism, guarantees an even more general image of medicine, such as the one that we have tried to go through in the first part of this article. The third reason derives from the second, concerning the feature mentioned that the aim of medical practice refers to ordered explanations and judgment of what is understood by health and illness, or disease, and interventions with the purpose of curing or treating. This definition of the aim of medical practice, being imbued with the medical image derived from the hermeneutic approach, theoretically subsumes a diversity of practices but precisely given the influence of such an image, it does not allow us to capture, for example, the problems raised by the practice of what Hermínio Martins called 'thanatocratic medicine' [42].

We argue that claims about medicalization and its correlative processes require not only a clear understanding of what medicine is but also of what social science is in its relation to medicine, an understanding that has as a necessary basis the very relationship between society and health, an enlarged knowledge-based approach to medicalization and medicalization critique.

10. Adding Reflexivity: On the Status of Social and Sociological Knowledge Regarding Medicine

Several authors have tried to study in more fundamental terms, following what we may consider knowledge-oriented approaches, the tensions between the HIMC and society as they are mirrored in the relationship between medicine and sociology. Under the old initiative of the Conferences on Social Science and Medicine, several papers of this type were produced, some published in proceedings or in the journal of *Social Science and Medicine*. P.M. Strong addressed related topics in this context. Although his papers are less well known and discussed than his article on the medical imperialism thesis, they contain important contributions to the theoretical and empirical evaluation of the above-mentioned relationships. We think notably of his text "Natural Science and Medicine: Social Science and Medicine: Some Methodological Controversies", co-authored with K. McPherson, originally prepared as a Joint Background Paper for the Seventh International Conference on Social Science and Medicine, Leeuwenhorst, The Netherlands, and reprinted in Strong's volume *Sociology and Medicine. Selected Essays* [158]. They frame medicine among the methodologies of the natural sciences and the social sciences, addressing issues that were left up in the air by the philosophy of science of the 1960s and 1970s and received by several sociologists, in this case, the possibility of theoretical and empirical progress in the social sciences, the inscription of all scientific activity in a sphere of morality, and its degree of proximity to the lay world.

Despite the relevance of an article of this caliber, it was probably Eliot Freidson who framed, contextualized, and discussed at various levels how tense relations between the HIMC and society, medicine, and sociology are. The topic was explicitly addressed by the author in a speech delivered at St. Thomas Medical School, University of London Special Lecture Series in 1980. His presentation resulted in the article expressively titled "Viewpoint: Sociology and Medicine: A Polemic", published in *Sociology of Health and Illness* in 1983 [9]. We consider it important to take up this article for four reasons. First, although Freidson was not, of course, the only one to see the problem, in this text, Freidson's synthesis of the issues at stake is unique, touching the nerve of the whole. Second, the issues are treated independently of his study of medicalization and largely beyond the analysis of the medical profession for which the author is chiefly remembered, taking a very knowledge-oriented approach. Third, it is an understudied text whose considerations have apparently been left outside the scope of Freidson's so-called 'legacy' in medical sociology and the sociology of professions. Fourth, Freidson focuses on developing several ontological, anthropological, ethical, epistemological, and political grounds specific to both

medicine and sociology, or the social sciences in general, that have been subsumed by the methodological constructivism that dominates the discussion.

Freidson's article is a largely speculative text based on the author's one-year experience in the United Kingdom. Margaret Thatcher was then Prime Minister. The more general assertions made by Freidson in this paper are that there is indeed tension between medicine and sociology but that both medicine and sociology face an internal intellectual crisis and a contemporary conjunctural social crisis. These crises, according to the author, could only be overcome through the mutual assistance of medicine and sociology. Let us follow the argumentative structure of the text closely. According to Freidson, the 20th century witnessed political, social, and cultural changes that constituted a source of transformation in medicine. These changes would have weakened the capacity of the medical profession to direct and shape the future in terms comparable to the previous century. This weakening would take place at a time that the author says to be "a time of reckoning which is also a time for reckoning" [9] (p. 208).

The idea of a time of reckoning designates a context of economic crisis characterized by policies of retrenchment or cost reduction of expensive public institutions, mainly affecting the most vulnerable institutions, which are, according to the author, "those that do not produce tangible goods" and "those designed to serve human needs which purely commercial enterprises tend to overlook" [9] (p. 208), namely health institutions, educational institutions, and welfare services. For Freidson, among the effects of this reckoning on the medical institutions is the transformation of medicine's economic position through the attempt to revive the earlier private medical practice and support cheaper physician-substitutes, employing paramedical personnel as practitioners rather than as assistants. These attempts are also followed by an encouragement of lay people to care for themselves.

In Freidson's reading, this transformation was implied, in turn, in a series of exemplary cases of the weakening of the medical profession. On the one hand, the very substance of medical practice undergoes some changes: the rising rationalization and regulation increase the routinization of medical practice, reducing the creativity of physicians and the craftsmanlike character of their activity, and the demarcation boundaries of medical control have been eroded, as have the boundaries of the authority and independence of individual clinical judgment and relations between colleagues in organized clinical practice, which also hinders personal responsibility. At the end of the day, medicine only distinguishes itself, like other specialized professions, for its technical autonomy. On the other hand, while lay and paramedical movements were strengthened, physicians' relations with patients and members of other occupations underwent profound changes.

For Freidson, it is incorrect to interpret these dynamics through the concepts of de-professionalization or proletarianization of medicine. We should instead understand them as representing a

> "movement toward an important reorganization of the profession as a corporate entity, toward greater control of the activities of the practising physician by that corporate entity, and toward a significant redefinition of the profession's relation to other occupations, to its patients, and to agencies of the state" [9] (p. 209).

However, it should be added that, in his text, Freidson makes it very clear that it is not just strictly institutional factors that change. For example, in the same flux, lay cognitive dispositions are also changing. According to Freidson, and in his own formulation, it increased the "public scepticism, if not distrust, of the motives of physicians and of the reliability and value of their expertise", the "fear of medical experiments, and concern about the long-term effects or side-effects of new drugs", "a great deal of interest in self-help and in methods of obtaining care without the need to resort to a doctor" [9] (p. 208). It is not only the medical profession that changes but also the dynamics between the lay reference and the medical reference.

Given the current configuration of medical practice, institutionalized health services, relationships between doctors and other health-related occupations, and their relationships

with the lay people and with the state, we may be tempted to classify Freidson's description as excessively prescient, but we should not be rushed into these qualifications. It would perhaps be more accurate and rigorous to assert that it is not a question of prescience per se but of coming across a description that integrates the process of research of the historical process, already studied by several authors and following different frames of reference, of the commodification of nature, knowledge, science, and also health and medicine. Freidson was one of the first to understand the direction and scope that this process was taking with respect to the medical profession and within medical institutions, foreseeing some of its theoretical and practical consequences and prescribing some solutions, also theoretical and practical. In this perception, the foundational tension between medicine and sociology that we have been referring to clearly emerges.

For Freidson, in the context of change analyzed, what is at stake is a macro question of how to establish a health system that guarantees decent and humane care for everyone so that health workers are not reduced to mechanized functionaries and that the economy can support without getting involved in cuts. According to Freidson, once again, in his own clarifying terms, "the critical question for medicine as an organized profession is the role it can play in those changes" [9] (p. 209). Contrary to the conservative attitude that has characterized medicine, its characteristic resistance to and prevention of change, the fundamental question would now be to understand how professionals could participate in it.

As soon as this question is posed, a new web of problems arises because the problems in question are economic, social, and political, with no reasoned answer based on medical knowledge. Medical knowledge is "knowledge of the nature and functioning of the individual organism" [9] (p. 210). To face the problems it faces, medicine needs the "knowledge about the nature and functioning of human institutions" [9] (p. 210). It, therefore, needs knowledge beyond its domain of objects, expertise, and training. In other words: physicians cannot give medicine what medicine needs. Those who can, according to Freidson, would be groups capable of providing knowledge about social processes related to medicine and collecting and evaluating reliable information about medicine, health systems, and health policy. Medicine thus needs knowledge provided by the social sciences, namely sociology. Thanks to these sciences, medicine could understand the institutions in which it participates and the forces in conflict. Ultimately, medicine needs sociology to understand its own social framework. This need is perceived, but is it justified by the effective capacity of the social sciences? Medicine can and should be based on sociological knowledge, but is this concretely possible? Can practiced sociology really support medicine, and medicine support it?

Freidson seems to think that, in fundamental terms, sociology can do it. According to the author, the value of sociology in this respect lies in two aspects. First, sociology more easily questions the settled assumptions and their corresponding political economy and cultural roots of health service and administration because sociology is, to use Freidson's words, "congenitally and deliberately outside" of its routines [9] (p. 219). Second, to use the author's formulation, sociology has a "disciplined character", in the sense that it has methods of data-collection of a systematic and self-conscious character, its analytical methods are theoretically organized, and, thanks to this set of technical and conceptual resources, it allows us to understand the basis for policy-making [9] (p. 219).

Notwithstanding, Freidson finds in real sociology several difficulties that complicate the possibility of responding to the needs of medicine. The first one he mentions is the public hostility towards sociology, which he encountered in English newspapers at the time. The second is the theoretical and practical fragmentation of sociology into three mutually hostile segments. First is the group of practical, empirical, and positivist sociologists, who are not averse to theorizing, although they may ignore its philosophical assumptions, but are mostly oriented to collecting quantifiable data on major institutions to respond to practical problems of the welfare state. Second, the philosophical, phenomenological, and interpretive group, whose members sometimes engage in abstract theorizing and criticism,

sometimes carry out empirical studies of a qualitative type, based on direct observation and personal interviews, getting closer to ethnography. Additionally, third, the critical theorists' group, including Marxists, a group that seeks to link theory and practice, rejecting scientific neutrality and seeking through theorizing and history to take an evaluative, critical stand, actively engaging in social and political transformation.

Freidson pays more attention to this second difficulty of sociological fragmentation. According to the author, the contempt between those groups is radical, each having its assumptions, its languages and its own purposes and dealing with mutual hostility. Freidson considers that the focus placed on mutual attacks has made sociology lose intellectual coherence, as, in the name of conflict, it abandons empirical research, which for the author represents a "retreat from the real world" [9] (p. 212). Far from the world, sociology would run the risk of becoming a "scholastic enterprise" or a "technical enterprise", in this case, at the service of its funders [9] (p. 212–213).

Despite the importance of these difficulties, it is necessary to go back and go deeper to discover the central problem as studied by Freidson. For this author, it resides in the self and mutual conceptions of medicine and sociology. Such conceptions are largely fallacious, but they become involved in a tangle that results in a mutual estrangement. In Freidson's terms:

> "Each needs the other, yet each alienates the other by self-serving and essentially dishonest conceptions of itself and the other. Each must face its own self-mystifications, its own myths" [9] (p. 212).

Regarding medicine, the author speaks of three myths especially in need of examination. First, he talks about the myth of experience, that is, the idea that only the physician "can say anything reliable and valid about medical practice and health care" insofar as it is the physician who has experience in these fields [9] (p. 212). This is a myth because it confuses the validity of different forms of knowledge: "the validity of lived experience with the separate validity of systematically gathered data" [9] (p. 213). This myth is reinforced by the belief that physicians' medical training would enable them to make scientific analyses of social processes concerning medical practice and health care. However, physicians' training in this area is minimal, and their particular experience may even bias their understanding of health care systems.

Unlike the first myth, the other two are not just about a certain understanding of medicine but more directly about the relationship between medicine and sociology. This is the myth of simplicity, that is, the idea that the knowledge needed to understand these processes is simple so that learning to study them will also be simple for a physician. In fact, to understand these processes, it is necessary to learn "how to collect data, process it and evaluate it, and how to think about the social world in abstract, conceptual terms" [9] (p. 213).

Like the second one, the third myth Freidson talks about is also directly about the medicine-sociology relationship. However, unlike the first two, this one is not about questions of knowledge but about a practical prejudice. This time it is the myth of technical aid that "if medicine does need sociologists, then they should serve merely as technical aides who study what they are told and merely report the results" [9] (p. 213). This notion leaves sociologists out of the processes of selecting research topics, formulating research questions, and criticizing the considered problems. Freidson thinks that this reduction of sociology to a technical enterprise would have an equivalent in medicine, a doctor whose semiology does not abandon the most superficial symptoms without ever exploring the pathological condition behind them.

In general sociology, that is, outside the narrower scope of the sociological study of health, illness, and medicine, Freidson also finds a number of myths that ultimately take their toll on this particular domain. As was the case in Strong and McPherson's text, the questions that Freidson poses here to think about the relationship between medicine and sociology retrieve fundamental issues left up in the air by the philosophy of science and received by different sociologists in contemporary times. In this case, all the myths referred

to by the author cut across traditional problems of epistemology, passing also through fundamental ontological, methodological, and axiological issues, all of which are taken here within the framework of human affairs and social problems. All the myths of which the author speaks in some way "reflect a tendency to confuse the logical constructs and distinctions of theory with practical human activity" [9] (p. 214). It is precisely the myths that arise from this confusion that is, in turn, at the root of the fragmentation that the author had found in the actual exercise of sociology, in its division into mutually hostile groups. In this interpretation, sociology's supposed lack of intellectual coherence seems then to be due less to the underlying theoretical statements than to the putative mythifications they imply or lead to.

It must be said that in pondering these general myths, Freidson reveals much about those who subscribe to them, but he reveals even more about his own theoretical standpoint in the social sciences. Freidson rejects diverse radical ontological, epistemological, methodological, and axiological positions. He does not accept that the structure of reality, the ways of knowing it, and the values that guide the perspective of the one who knows it can be absolutely defined.

Thus, the belief that facts can be known in an absolutely objective way, namely through the use of scientific measurement techniques in empirical research, is referred to by Freidson as the 'myth of objectivity and of positivistic method'. Those who adopt this myth seem to take the world as given, proposing only to describe and analyze it. Against this myth stands the diametrically opposed view that subjectivity is a sufficient guarantor of our knowledge. This view Freidson calls the 'myth of subjectivity'. It would have entailed ignoring or even arguing against the empirical practice, various forms of data collection, formal methods, and analytical techniques.

According to Freidson, this polarization results in itself from the abstract formulation of the theory. However, the author argues that while pure objectivity cannot be guaranteed, neither can we think of the empirical social world from purely logical categories. From the critique of positivism's exaggerations, we cannot derive a denial of all forms of empiricism. The author does not try to pose the question in terms of choice between theory and empirical research. It will be possible for Freidson to take on some values of positivism without being a radical positivist. Freidson declares sociological practice is not faced with epistemological absolutes; it is "a matter of something in between", and what matters is "the question of degree" [9] (pp. 215–216). Theory elevates this practice above technique because it offers insights and guidelines; namely, it allows us to formulate epistemological and methodological criteria. Then, careful empirical research will make it possible to document the characteristics of social units. In this work, qualitative methods should follow the quantitative data, providing them with their social context. This is what medicine needs: "a sociology committed to thinking about theory while testing its mettle in the ambiguous empirical world" [9] (p. 217). We believe that the same can be said about the other social sciences.

Alongside the myth of subjectivity, as a critique of positivism, Freidson finds two other myths. One is the 'myth of commitment', that is, the idea that since there is no axiological neutrality, sociologists should not be interested in research for its own sake; they should choose their values and take them as the ends of their research. The problem here, for Freidson, is the lack of attempt to reduce personal bias.

A correlative myth will be that of criticism, the myth that 'a critical position is truly useful for actually improving the character of human life'. A basis of this myth lies in the idea that there are deep-seated forces that make the world what it is, and in particular, that some of these forces oppress human life. Freidson does not object to this idea. The procedure stemming from this basic idea is that the researcher must actively assess these kinds of forces. However, the author believes that those who adopt a critical position end up being more concerned with the critique than with its substantiation, the actual analysis of the forces in question, and the specification of measures of a social change of

an alternative. Ultimately, what ends up happening is that inquiry is replaced by moral judgment and moral commentary, by indignation.

Freidson states that in the context of the study of health, without specifying much further, the Parsonian notion that medicine is a form of social control was reiterated and related in the critique of a capitalist political economy but was largely reduced to a "rhetoric of outrage that medicine is part of a system of social control" [9] (p. 215). Indeed, perhaps we can say that a good deal of this, already with a great deal of forgetting of Parsons' original contribution, is what is going on with current critiques of medicalization in a pandemic context. Freidson tells us that it remains to be seen how medicine can exist without social control, taking what he considers to be the "irreducible elements of social control and authority" arising from medicine's own professional, cognitive, and technological frameworks and seeking to dismantle other oppressive conditions [9] (p. 216). Thanks to the knowledge-based approach, we already have a renewed idea of this relationship, but we cannot stop there.

Freidson ends his text by adding a myth related not to medicine or sociology but to the agencies involved in the process of sponsoring and funding sociological research, which he considers to be the third part of the collaboration between medicine and sociology. It is now the myth of administrative data, that is, the idea that administrative records are transparent, that they speak for themselves. According to Freidson, this is a myth because administrative data are limited by their very nature. They result from participation in a structure or system about which they provide evidence. These data are formed by uniform, standardized activities and operational categories that schematically organize information from official records about certain outcomes of this structure so that they can be compared according to different parameters. To overcome this myth, it is not necessary to abandon administrative data sources but to recognize their limitations and subject them, as in the case of other myths, to the research of the social processes in which they are involved.

We do not have to agree theoretically, or politically, for that matter, with all of Freidson's stances. However, Freidson presents crucial knowledge-based parameters for considering the tense relationships between the HIMC and society and between medicine and the social sciences. These parameters demonstrate that we are not dealing with inert abstractions but with areas of thought that provide theoretical assumptions and practical prejudices about the field of objects that they seek to understand and within whose scope they seek to intervene. The assumptions that Freidson speaks of, the various myths he refers to, are involved in expanding a knowledge-based approach to medicalization. In a way, this expansion corresponds to a theoretical harmonization of the relationship between epistemology and (not only) social ontology, modes of knowledge and conceptions of (not only) social reality.

We are arguing here that what is also at stake is how different forms of knowledge put the relationship between the HIMC and our very conception of society. The two modalities of medicalization that we have been exploring both fit into a somewhat skeptical approach to the possibility of knowledge. The critical attitude, we must recognize, can often, in the case of the medicalization critique movement of which Freidson himself is a part, be reduced to moral judgment and commentary, but this is not necessarily so, provided the substantiation of the oppressing forces which become the object of criticism. At least, in the diverse formulations of medicalization critique, they tend to oppose forms of dogmatism without necessarily falling into radical skepticism. At the very least, there is an evident skepticism in the non-acceptance of the biomedical model, which is widely understood as a set of dogmas originating in the natural sciences. In Freidson's terms, by recognizing the specificity of sociological knowledge in the study of health and medicine, the myths of experience and simplicity are broken. By taking an active stance in the face of the problems in question, one breaks, at least in principle, the myth of technical aid and the myth of administrative data.

However, the conflict between the myths of objectivity and subjectivity seems especially relevant to us, as it is in this that the fundamental field of distinction between

the modalities of medicalization and their versions of criticism is inscribed. Seeking to overcome the deficit of reflexivity that we have noticed and dispensing with a merely professional approach, and also understanding that it is not only the role that the concept of social control plays in the critique of medicalization that is at stake, despite its tremendous importance, it is necessary to leave the macroscale of the relationship between social science and medicine to look at the smaller representation of society, or of the social, and social science in this relationship. What our interpretation suggests is, therefore, that the relations between the HIMC and society in general and the critique of medicalization, in particular, are reconstructed from the intersection between the dogmatism–skepticism axis regarding the problem of knowledge and the objectivism–subjectivism axis, concerning the conception of social reality. From what Freidson puts forward, we can observe within the framework of a knowledge-based approach, for example, that, when adopting a realist point of view, the repressive-negative version of medicalization critique does not adopt the subjectivism in which the constructivist version ends up falling. The underlying critical attitude will not allow, in turn, to fall into the contrary myth of objectivity and the positivistic method. We believe that it is in the repressive-negative version of medicalization critique that the degree criterion is met. Nevertheless, it is now essential to underline that this can only be understood consistently following the relevance given to medical knowledge by the constructivist critics of medicalization and the subsequent bio-, cam-, pharma- extensions and the problematization of the notion of social control.

These ideas can be updated in the frame of different contexts. After the scientific and technological transformations that we have witnessed since the 1980s and given the pandemic scenario caused by the global spread of the new coronavirus, a profound reflection on the HIMC and society relationship and the corresponding relation between medicine and social science is imperative. We believe it is within the scope of an enlarged knowledge-based approach that we will be able to lay the foundation for the understanding that the pandemic situation precipitated the emergence of an already agonistic but more latent debate. On the one hand, we have been watching the strengthening of skeptical discourses concerning the regulatory and normalizing status of science and medicine. On the other hand, a certain positivist resurgence of scientific knowledge has also become notorious, namely through the more reiterated and emphatic use of the idea of the consistency of scientific evidence. The disciplinary approaches of these different domains have actually contributed to the escalation of a greater theoretical and epistemological insularity.

11. Concluding Remarks

Contrary to the option adopted by some contemporary authors, the train of thought we sought to develop did not imply the abandonment of the concept of medicalization. As we have seen, the concept of medicalization has integrated various fields, levels, objects, scales, and meanings; it articulated new structures, new agents, and new behaviors; it has been explored by related concepts, such as those of biomedicalization, camization, pharmaceuticalization, or therapeuticalization. The critical reassessments are indicative of the multiple contributions developed, the adaptative nature of the medicalization processes, and the elasticity of this concept itself.

What we sought to do was to scrutinize this long path of theoretical production, with the explicit purpose of showing to what extent some of the foundations that underlie the most widely disseminated trends of social research produce, or reproduce, an analytical narrative whose focus accentuates, in a too generic and totalizing way, ideas that reduce the diversity of forms of knowledge, paying special attention to medicine and the social sciences, integrating and expanding the notion of the transition of the discourse on HIMC.

We hope with this we can also contribute to point out, especially considering the present pandemic conjuncture, the necessity of a broad theoretical clarification in the universe of health, illness, and medicine. From this point of view, we maintain that a certain eagerness to problematize and critically reconstruct the limits of the assumptions of the so-called biomedical model may have a potential effect on the reduction of, on one side, the

idea of social science and, on the other, of medicine itself to mere caricatures. For a discussion that seeks to contribute to understanding the implications of these generalizations, it is vital to show to what extent the nature of the social approaches to the HIMC is developed in coherence with some assumptions that, by being constitutive of the most structuring conceptions of some disciplinary fields themselves, can give rise to a potentially sectarian view, assumptions with which we have not ceased to confront throughout our research and from which we have sought to depart.

The first assumption corresponds to a characteristic that is, moreover, at the basis of the very disciplinary identity of sociology of health and concerns its own object of study. It is, basically, about recognizing that there is, since its emergence as a subdiscipline, a well-established division of labor between the social sciences, especially sociology, and medicine. This division is responsible for a segmentation that blocks dialogues and articulations, contributing, in this way, to the emergency of and to feed approaches that are not only distinct from each other but tend to be captive of an insularity that makes common understanding difficult.

A second assumption is often responsible for interpretative generalizations about medical knowledge. This is the use of conceptual categories that shape the historical-sociological analysis of the emergence of the biomedical model and the institutional development of modern medicine in the 19th and 20th centuries. These broad categories allow, in fact, a certain historical tidying up. However, they end up unifying, reifying, and giving a homogenizing coherence to complex realities, subverting the understanding of empirical realities that are not devoid of their theoretical continuities and material contingencies.

Finally, it is also important to consider a third assumption, this one related to the characteristic biophobia of some social scientific approaches, which is prolonged, at least in principle, by the Foucauldian and constructivist conceptualization of the anti-realist-positive modality of medicalization. It is a perspective that neglects the biological and clinical aspects of illness, leading to paradoxically breaking with the very clinical diversity of illness.

What seems to be theoretically more reasonable, analytically more productive, and normatively more responsible is the problematization of the supposedly radical unitary character of medicine, promoting a look that is less totalizing and circumscribed to large generalizing, inadvertently supported on, at the limit, reductive categories. It will not be unimportant to equate an approach that assumes and contemplates the more diverse and fragmented nature of medical vocation. However, not in the sense of presuming them to be erratic or devoid of a specific theoretical or epistemic unity. It is crucial to recognize that medicine, as a practice and field of social action, is not monolithic and, therefore, its empirical reality is not exhausted in the unity and coherence provided by analytical categories, but at the same time, it has ontological, cultural, moral, political, and epistemological frames of reference. In other words, we have to be careful not to fall into the paradox that, between professing the objective of conferring greater neutrality to medicine, or to medicalization processes, or the objective of lending them a strong evaluative charge, we end up neglecting the mosaic of what is understood by health, illness, disease, and medicine. Any effort that entails going beyond the perpetuation of the caricature, whether through unreasonable praise or unlimited criticism, around the biomedical model is in itself a serious and relevant effort with the potential to mitigate mutual misunderstandings and mystifications.

Our reconstruction of the concept of medicalization and of the movement of medicalization critique allows us to defend, against the background driven by the mentioned assumptions, a version of medical skepticism moderated by the recognition of the multi-level conditions of health and illness, namely the constraints of the socio-economic structure produced by the capitalist mode of production. Within the social studies of health, illness, and medicine, this view is contained in, or translated into, an approach to medicalization that is both realist and knowledge-based. This means that it is necessary to collect the results of the development of medicalization studies but also to go back. It is necessary,

and in the current pandemic context, this seems to us to be a fundamental task, to take a knowledge-based approach, but to broaden it to include sociological forms of knowledge and thus be able to reevaluate the assumptions that threw us into the very development of the knowledge-based approach. In a context where there is a notorious strengthening of the skeptical problematizations related to the scientific and political status of medicine, a dogmatic response that resurfaces a positivist and imperialist approach to medicine is not acceptable. The necessary re-evaluation needs, in our view, to reorient the knowledge-based approach towards realism, which historically had been parting the way. This is our time for a new reckoning.

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