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Diagnosis: Are we medicalising human experience?
A radical review

The process of reaching a diagnosis, communicating it to a patient and using this information to guide management is central to good medical care (1). This practice was revolutionised during the "Golden Age" of medicine in the 20th century when new diagnostic tools gave doctors increasing power to understand human disease (2). In contrast, the 21st century has not brought such dramatic improvements, nevertheless, the remit of medicine within society has continued to expand. Problems once considered non-medical are increasingly dealt with in a healthcare setting and doctors are expected to draw upon their medical knowledge and training to support individuals in a wide variety of personal situations.

The term 'medicalisation' suggests that the expansion of the medical domain has progressed beyond that of disease and into normal human experience. One approach to evaluating this is to consider what it is diagnosis aims to achieve and whether these aims are still being met. It will be demonstrated that an increased medical understanding of human experience can improve individuals' health as medicine aims to do, however, this is not universally true. Indeed, medicalisation carries many risks and in some circumstances may even be counter-productive. A balancing act exists between the risks and benefits of diagnosis and therefore a radical approach in which the patient's preferences are placed at the centre of medical diagnosis should be advocated.

Autism provides an example of the potential benefits that can be gained through diagnosis and medicalisation. A diagnosis of autism is based on behaviour, rather than biomedical markers, and is an example of how a social problem has become understood medically. The key aims of providing a diagnosis for a patient are to help improve their understanding of their condition and enable them to access support (1) – are these aims achieved in diagnosing autism? The prevalence of autism has increased in recent decades as consequence of increased screening and changes to diagnostic criteria (3). Children with autism have poorer outcomes at school and adults with autism experience difficulty finding employment (4). If more individuals are appropriately receiving a diagnosis of autism it may provide a reassuring explanation for the difficulties they have encountered in school and employment. Not only this, but a diagnosis may improve outcomes in these areas by providing a 'passport' to services. For example, early intervention in autism improves functioning by increasing verbal ability (5) and specialist employment support for adults with autism increases rates of employment (6). In this case, it could be argue that we are indeed medicalising human experience by labelling behaviours with an autism diagnosis but it is possible to justify this as the aims of diagnosis are being achieved.

This argument relies on the condition that these services are available to those with an autism diagnosis. A recent survey reported that the vast majority of individuals with an autism diagnosis have inadequate support services (7). This poses the question: is it ethical to diagnose individuals with a condition if the appropriate services are not available for them? Furthermore, there are also potential 'side-effects' of diagnosis, such as discrimination in relation to employment and insurance. Rather than a diagnosis providing reassurance and explanation, it may leave individuals feeling confused and without appropriate support. Therefore, individual preference in diagnosis is key: some may wish to formulate a medical explanation for their difficulties, whereas others may feel the risks of medicalising their issues outweigh the potential benefits. The balance between risk and benefit may change over time, for example as support services become more or less available, or as discrimination becomes more or less prevalent.

The argument for individual choice can be strengthened by looking at the diagnosis of hypertension. There is substantial evidence from prospective, long term trials that treating hypertension reduces the risk of heart attack and stroke (8). These medical benefits of treating hypertension are evidence-based, however, there is less understanding into the personal effects of medicalisation that transforms people into patients. Expanded screening programmes mean more people are gaining a diagnosis of hypertension and consequently a lifetime on multiple medications despite reporting no symptoms. People display a range of emotional reactions to diagnosis including: shock, rushing into treatment without due consideration, or reacting very negatively by blaming themselves or healthcare professionals (9). Furthermore, the manner in which doctors frame risk surrounding a diagnosis and the benefit associated with a treatment can greatly influence a patient's reaction. Research has shown that when this information is framed from the individual patient's point of view rather than in terms of relative risk (more likely to be the doctor's point of view), they are far less willing to proceed with treatment (10). If patients are unlikely to pursue medical treatment when the risks and benefits are framed from their own perspective it is possible to argue that diagnosing hypertension is not achieving its aims and is unduly medicalising people that are otherwise well.

Personal preference is not the only argument against this form of medicalisation, it is also possible to question the validity of the evidence that demonstrates the benefits of diagnosing and treating hypertension. There is good evidence that drug trials are focused on producing drugs that are financially profitable, rather than those that represent the biggest benefit to patients (11).

Therefore, it is wise to be cautious in evaluating the pharmaceutical evidence, given that the diagnosis of hypertension has not only transformed millions of people into patients, but also millions of patients into consumers. Furthermore, it has been demonstrated that up to 30% of individuals diagnosed with hypertension in clinic, have a normal blood pressure reading when taken at home (12), thus questioning the validity of medicalising individuals without medical complaints.

Despite these limitations, there is increasing support for expanding this area of medicine to create a new diagnosis of ‘pre-hypertension’, which can also be treated (13). The potential risks of diagnosing prehypertension must also be explored before further medicalisation occurs. Illich proposes the notion of ‘counter productivity’ in which aspects of modern society start to work against their original aims (14). Diagnosing pre-hypertension may prove to be counter-productive to individuals’ health if the benefits from diagnosis and drug treatment are offset by the inaccuracy of measurement and questionable motives of drug manufacturers to expand markets. There are also the risks of discrimination associated with having a medical diagnosis, as well as a risk of increasing hypochondria by encouraging patients to become ever more reliant on their doctor for all problems. Evidence from drug trials alone is insufficient and it is important to acknowledge that healthcare is increasingly aiming to improve patients' lives from their subjective viewpoint rather than focusing exclusively on traditional medical criteria (15). Therefore, a holistic approach to diagnosis is required, which takes into account the patient’s own views and their understanding of the associated risks and benefits.

Another example of medicine’s expanding sphere is a recent scheme to introduce job advisors into General Practices (16). Is it the doctor’s role to ‘diagnose’ unemployment and ‘prescribe’ job counselling within the healthcare setting? Some patients my benefit from the convenience, but others may be concerned that their healthcare is becoming contingent on completing other social obligations. This may be an example of social iatrogenesis (14), whereby aspects of the medical system cause harm to patients. The negative connotations associated with job centres and finding work may discourage individuals from seeking medical help even when they are in need. In this case, medicalisation may be working against the aims of medicine by endangering individuals’ health.

Having considered some of the research evidence for and against medicalisation it is worthwhile exploring a patient’s own experience to illustrate the potential impact of diagnosis. Szasz describes an example of a young depressed man who reached out for help and was consequently detained on a psychiatric ward (17). The young man reflected on his experience: “I am more depressed than I was before, having been traumatized by my experience with the mental health care system”. This provides a personal example of iatrogenesis and how the medicalisation of depression may not always be consistent with the aims of diagnosis.

It would be unreasonable to argue that medical diagnosis of human experience has not helped some individuals. Medical research demonstrates the benefits of medicalisation through diagnosis, however, there is a relative lack of awareness of the risks carried with diagnosis, including insufficient support services, potential discrimination and increasing medical and social iatrogenesis. Consequently, in order to justify increased medicalisation there must be good evidence that diagnosis is beneficial to patients and outweighs the associated risks. Where this balance is unclear, as in many cases, patients should be put at the centre of the decision making process. As healthcare increasingly acknowledges the role of patient values in treatment choices, it must expand this principle to include the process of diagnosis. This will ensure that the medicalisation of patient's experience is not to their detriment and consistent with the doctor's duty to 'do no harm'.

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