



The study of processes of medicalization in Latin America

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Abstract

In recent decades, an ever-increasing cluster of phenomena has attracted the attention of social scientists and historians of medicine: processes of medicalization. As in other regions, Latin America has been affected by these phenomena. This article surveys recent literature involving sociological studies of these processes in the region, in order to provide an overview of the issue. It explores the theoretical transformations linked to the concept of medicalization in the contexts where they originated. It then analyzes the ways in which the concept has been appropriated by the social sciences in Latin America in order to describe the various phenomena associated with medicalization in the subcontinent.

Keywords: medicalization; Latin America; medical sociology; health.

The importance of western medical science in contemporary societies is undeniable. The extent of its influence, its successes as well as its risks have increased since the eighteenth century, making its presence ubiquitous in the life of billions of human beings. And while this process now spans over three centuries, in recent decades there has been a rising number of occurrences of a cluster of phenomena of interest for historians and social scientists who focus on medical topics: processes of medicalization. These refer to processes whereby an ever-growing number and range of conditions, behaviors and experiences are categorized as diseases or disorders, and are therefore incorporated into the domain of biomedical knowledge and practice.

Medicalization implies creating categories and standards that inform norms, discourses and practices in ever more diverse areas of life. These processes are carried out in very different ways: medicine nowadays is a huge transnational industry; a field of intense scientific-technological research; and a powerful discourse on life, death and well-being. Overall, the dimensions of medicine have allowed it to expand its jurisdiction to a level at which, according to some analysts, the phenomenon constitutes “one of the most potent transformations of the last half of the twentieth century in the West” (Clarke, 2003, mentioned in Conrad, 2007, p.4). In response to these processes, the very concept of medicalization has ceased to occupy a peripheral role in the study of the relationship between medicine and society, and is now central to the field. Along with this changes, the concept has undergone important semantic and theoretical transformations.

Latin America has been affected by the phenomena of medicalization, as shown by the historiography of medicine (Armus, 2005, 2002; Hochman, Armus, 2004). However, social science researchers are only just starting to analyze the particular features these phenomena acquire in countries across the region. Nevertheless, it is possible to construct an initial assessment of the current state of affairs, focusing mainly on sociological studies. Studies of medicalization intersect with other research agendas, such as the history of medicine and of public health, with which they obviously share points of contact although they are not identical (Armus, 2005, 2002; Espinosa, 2013; Birn, Necochea, 2011). This analysis acknowledges the contributions of historiography, but it is not the topic of discussion.

In order to focus on Latin American socio-scientific research, this article is structured as follows: firstly, we account for the historical changes related to the concept of medicalization, as seen in the contexts where it originated. Secondly, we analyze the ways the concept has been appropriated by Latin American social sciences in order to account for the various phenomena associated with medicalization on the subcontinent. This second part is based on the analysis of recently-published works on such processes in Latin America.¹

The concept of medicalization

In the last forty years, the topic of medicalization has become relevant for the social sciences in general and for medical sociology in particular.² Throughout its history, the concept itself as well as the phenomena it refers to have changed substantially, leading to a polysemy that accounts for the different views of the process and the variety of work agendas and research strategies. According to Joseph Davis (2010), this polysemy is the result, on the one hand,

of the difficulty of establishing clear boundaries between medicine and other discourses and practices that use the language of normalcy and pathology, but do not use therapy or the medical model; and, on the other hand, of the broadening of medical jurisdiction into spheres that were not formerly its domain.³ To contextualize our main objective, we will provide a brief overview of the transformations of the concept.

Theoretical antecedents for the concept of medicalization

There are two traditions of thought that converge in the emergence of the concept of medicalization in English-speaking academia. The first stems from the intellectual developments in the counterculture and the new left that took place in the late 1950s and particularly in the 1960s. This era of social critique witnessed the rise of antipsychiatry, a movement that questioned the institution of psychiatry and its explanation of health and mental illness.⁴ Thomas Szasz's (1960) conceptions of psychiatry as an institution of social control and of mental illness as a myth were widely influential in the tradition of sociological critique.

Antipsychiatrists were joined by others who extended this critique of mental health to the discursive hegemony and practice of medicine as a whole; these included social scientists. In his *Medical nemesis (Némesis médica, 1975)*, Ivan Illich (1975) coined the term "social iatrogenesis" to criticize the use of medical categories to understand and deal with everyday life problems. Illich argued that the medical system in modern western societies not only fails to cure people, but leads to the creation of diseases.

Within this tradition we cannot fail to mention the influence of the new history of psychiatry pioneered by Foucault, who analyzed the medicalization of behavior deemed "insane." Although we will explore the impact of this author's thesis in more detail later, we should mention at this point that in his work during the 1970s he characterized medicine as a device for social control that exercises a vigilant, normalizing gaze over its subjects, a thesis that has been very influential in Latin America ever since.⁵

The second theoretical tradition that contributed to the construction of the concept of medicalization comes from sociology, and is based on the notions of illness and the sick person developed by Talcott Parsons (1951). This author considered that illness, like crime, was a form of deviance. However, unlike the criminal, the sick person is not blamed for his condition, although he is expected to cooperate in his healing process. In other words, society demands that he assumes the role of patient, by complying with the treatment ordered by doctors.

In the early 1960s, various critiques of Parsons' concepts emerged. While they used the concept of the sick role, they argued that deviance does not stem from the individual, but from society, which defines him as deviant in order to control him. This theoretical shift from the individual to the social order affected researcher's views of the medical institution, which led to the incorporation of labeling theory and to sociological studies on health (Davis, 2010, p.214). Noteworthy contributions to this line of thinking include Ervin Goffman's (1961) work on the patient's moral career.

The term "medicalization" first appeared in sociology in 1968, in a chapter by Jesse Pitts (1968), and was rapidly incorporated by other authors such as Irving Zola (1972), who was the first to argue that this process was not limited to psychiatry. Likewise, Eliot Freidson

analyzed the expansion of medicine's jurisdiction (Conrad, 2013, p.196). Both critiqued its claim of neutrality and objectivity, arguing that medicine effectively imposes behaviors and notions of normalcy onto society.

Sociological studies on medicalization from the 1970s and early 1980s shared a negative view of the process. The “medicalization thesis” critiqued medicine's universalist and imperialist aspirations, the reductionist focus linked to those premises, and the emphasis given to the study and treatment of symptomatology located in the individual, at the expense of social factors involved in health and disease processes (Ballard, Elston, 2005).

From this standpoint, the medical institution and doctors themselves appear omnipresent and omnipotent and medicalization seems an inevitable, irreversible and ever growing process (Davis, 2010, p.213) that turns patients into passive, defenseless individuals who are dependent on medicine and its treatments. This phenomenon emerged from and strengthened the power of the medical institution, which in turn serves the various interests of the State, of capitalism and/or of the profession itself.

Marxist and feminist-based studies used the “medicalization thesis” to criticize the authoritarian nature of medicine and medical professionals' role in constructing a capitalist, patriarchal order. From a Marxist perspective, medical practice is understood in terms of class domination: the medical institution appears as one of the driving forces behind the process and part of the machinery of capitalism (Navarro, 1976; Waitzkin, Waterman, 1974). One of the benefits that medicalization brings capitalism lies in its ability to present problems arising from social inequality as individual pathologies. This translates into a search for personal instead of political solutions for class inequalities produced by the social order. It is also argued that a rise in the number of diseases leads to increased consumption of all types of treatments, which benefits both doctors in particular and capitalism in general.

Feminists critique medicine's expansionist goals, focusing specifically on the discourses and practices directed towards women. They reflect on the way the medical institution has appropriated women's bodies and experiences, particularly in studies on the usurpation and control of reproduction and birth by doctors, most of them male (Ballard, Elston, 2005, p.234). They also critique medical discourses and practices related to women's mental health that help maintain the patriarchal system (Chesler, 2005; Showalter, 1987; Busfield, 2011).

The 1990s: the emergence of a complex vision of medicalization

As a result of research into concrete instances of medicalization, a much richer and complex vision of these processes arose in the early 1990s, leading to a conceptual shift whereby they ceased to be regarded as intrinsically negative. Several authors abandoned a normative view of the process, arguing that it leads, among other things, to characterizing medicalization as over-medicalization (Conrad, 2013, p.199), and conceptualizing it as synonymous with medical control and use of medication.⁶ One of their most salient arguments was that medicine's power had been overestimated;⁷ according to them, research showed some loss of prestige of medical practices and discourses.

The inexorable broadening of medical jurisdiction was questioned, as authors acknowledged that there were also processes of de-medicalization being driven by a variety of subjects; they critiqued a vision of medicine that stresses only its normative and authority-conferring

abilities, which reduces it to a device for social control, ignoring its healing potential. In that sense, despite the implacable criticisms leveled at modern medicine by authors such as Foucault, Illich and Szasz, it is impossible to ignore the fact that its expansion is related to its success. This success has its origin in seventeenth century western medicine, which is based on an objectifying gaze of science that presupposes concepts about the body, its functions and the causes of disease, as well as meta-medical premises about the meaning of disease (Worsley, 1999). Nineteenth-century advances in organic chemistry, biochemistry and bacteriology, the birth of modern pharmacology and the subsequent development of powerful technologies for surgery and medical imaging (Ortega, 2010) made it possible to prevent and treat multiple conditions. And even though, as critics argue, the risks and limits of biomedicine are systematically undervalued, its curative powers – and not only its biopolitical dimensions – are central to comprehending why it has become the hegemonic medical model (HMM),⁸ despite the negative consequences of this hegemony. Also during this period, authors re-valued people's perceptiveness and agency; their active participation, whether resisting or promoting the medicalization of their conditions, was acknowledged, individuals were no longer presumed to be defenseless victims of these processes.⁹

An important conceptual change, closely linked to this re-evaluation of agency, was the recognition that medicalization is a process driven by different actors and forces – health professionals, lay people,¹⁰ patient advocacy groups,¹¹ pharmaceutical companies, NGOs (Frenk, Gómez-Dantés, 2007, p.160), international organizations, governments (Elbe, 2012), insurance companies etc. They are involved in a dispute to define something as medical because this definition is a central feature of processes of medicalization. The term alludes specifically to a process whereby a problem is defined as a medical condition, using notions of health and disease, the lexicon of medicine and the idea of therapy. Definitions constitute a process negotiated by different actors who are competing for jurisdiction over the description, the explanation and the right to intervene in a phenomenon. In this negotiation, not all the participants have the same resources and influence to impose their demands.¹²

Studies of medicalization deal with four types of phenomena currently defined as falling under the jurisdiction of medicine. Originally, Peter Conrad, whose work is central to this topic, recognized two such types: behaviors defined as deviant by social norms (Conrad, Schneider, 1980) – insanity, addictions, and homosexuality, among others – and natural life events or processes – baldness, menopause and andropause (Conrad, 2007). These conditions are considered natural in the sense that they occur frequently or can be expected at certain stages of life, they are not obviously pathological. About ten years ago, Davis (2010, p.220) added two more typologies. The first is related to everyday problems and problematic experiences – such as shyness or obesity – that used to be considered unpleasant and undesirable but not pertinent to medicine, and for which different treatments now exist. The second, enhancement, involves products used by healthy people in order to improve certain aspects of their bodies and/or their mental capacities, such as cosmetic surgery and concentration-enhancing medications. The issue becomes more relevant for the social sciences as technoscientific advances enable interventions in organs, systems and even genes. While Conrad and Davis's typologies are broad and allow us to recognize and differentiate specific instances of medicalization, they do not encompass all possibilities. As they and other authors

point out, we need to stay on the lookout for emerging forms of medicalization (Clarke et al., 2010).

As a result of the theoretical changes described above, scholars in this field insist on the need to analyze the specific characteristics of any given process of medicalization. As the sociocultural historians of disease have argued,¹³ only by acknowledging its particular historical, social, cultural and economic conditions can we account for its complexity and dynamism, the multiple actors involved and its local characteristics (Bianchi, 2010). We will now focus on this issue, analyzing the current state of research into processes of medicalization in Latin America.

Studies on medicalization in Latin America: the essential tension

Studies on processes of medicalization in Latin America stem from the theoretical developments presented earlier. However, they do not show the same progression: the use of authors and concepts that have been critiqued and enriched in their original contexts are still being used mechanically, although some studies are starting to appropriate current concepts and arguments.

In studies of medicalization in the region, the prevailing theoretical background is based on Foucault's theses about medicine as a biopolitical strategy of the modern State. Viewed thus, this practice constitutes a technology of control that is comparable only to law in its ability to categorize people and behaviors. It is considered a technology that implants itself ever more deeply into society, encompassing the body and mind of individuals; one that has epistemic, moral and political dimensions, and that imposes itself both formally and informally as one of the crucial institutions in the collective life of nations.

One of the reasons why medicalization has spread throughout Latin America has been the marginalization of alternative methods of treating ailments, "including both therapies of empirically proven efficacy as well as deprofessionalized forms of all sorts of processes, from childbirth to death" (Márquez, Meneu, 2007, p.65).¹⁴ In this process, the role of the State has been crucial, until very recently the HMM was the only model authorized in the public health system.

While the relationship between medicine – conceived as a field of knowledge and profession that requires national accreditation – and politics is an unavoidable dimension for understanding how biomedicine became hegemonic; we should not ignore the cultural dimension of the phenomenon, in contemporary societies science has an epistemic authority traditionally associated with progress. Processes of consolidation of modern nation States were accompanied by the creation of health care systems under the principles of the HMM. In the nineteenth century, Latin American countries attempted to emulate Europe and the United States despite the obstacles involved in implementing institutions and practices conceived in contexts with very different sociopolitical, economic and cultural conditions. Historiography on public health in Latin America confirms that, "public medicine appears progressive in nature, the happy result of the association of biomedical science with the rational organization of society" (Armus, 2002, p.42).

The relationship between medicine and politics shifted markedly during the Second World War, specifically in 1942, when the Beveridge Plan in Britain enshrined the right to health (Foucault, 1996). This document established that in addition to family allowances and full employment, the country would provide medical care to cover all the requirements of its citizens via a national health service. Even though the aims of the plan were obviously not entirely achieved, it had widespread impact in terms of defining the social security agenda in other countries, making health a right (Abel Smith, 2002). Since then, medicine – like other modern institutions – has operated under constant, irresolvable tensions. It became the source of benefits and risks; an instrument of normalization and control, and simultaneously a right demanded by individuals and groups in their struggles to construct citizenship (Stolkiner, 2010). Medicine has a double-edged nature that cannot be ignored; Anthony Giddens (1993) refers to this as a constitutive paradox of modern institutions. Studies produced in Latin America clearly echo these tensions. We found texts that are very critical of the expansion of the HMM and, at the same time demand that the State meets its obligation to provide healthcare services for the population. This constitutes an example of how medicine has become an object for struggles that can have not only diverse but contradictory objectives. On the one hand, advances of biomedical research create moral dilemmas over the definition of what it means to be human that are becoming central.¹⁵ On the other, millions of people are still dying of preventable, curable diseases.

In Latin America, existing analyses show that processes of medicalization take on characteristics that merely add to the age-old inequalities in the region: the right to health is not granted, because large sectors of the population have limited access to basic services and medications. At the same time, there is an overuse of medications and services among the sectors of society that are the most economically advantaged and have the highest level of education, sectors that replicate American health consumerism (Alcántara, 2012). Medicine veers between the extremes of exclusion of some populations and overmedicalization and hyperconsumption of medications on the part of others (Natella, 2008). Discussions about medicine nowadays move between these two opposite poles; these discussions show a marked concern with economic dimensions, which are emphasized in Latin American research.

Medicine and macroeconomics

With the change that took place in the middle of the twentieth century, medicine entered both the arena of political struggle and into macroeconomics in two-fold manner. Ensuring access to services and medications to cover the population's basic needs is inscribed, as mentioned before, among the tasks of the State. However, production and distribution of drugs has largely been handled by transnational industries representing private interests, and because of this, Latin American States have limited themselves on many occasions to exercising regulatory functions (or in many cases deregulation), the extent of which were dependent on the behavior of the global financial and commercial markets.

One of the changes shown in studies of the health care sector involves the transformations that have taken place since the 1990s thanks to the competition for resources between financial capital and the pharmaceutical industry. While the latter's role has traditionally been that of principal ally of medical professionals, who constitute its privileged interlocutors,

the growing protagonism of financial capital in the administration of resources designed to cover public and private medical services has meant that in some countries in the region, the medical-industrial complex has responded to the challenge by implementing marketing strategies that are directed at consumers – bypassing doctors – but that also pressure state regulatory agencies to recognize new diseases, risks and medication-based treatments (Iriart, 2008; Ferguson, 1981; Cabral Barros, 2008; Faraone et al., jun. 2009, 2010).¹⁶

This growing influence of the pharmaceutical industry and financial capital on processes of medicalization allows Latin American authors to argue that there has been a shift towards a new brand of biopolitics (Rodríguez Zoya, 2010) in which market interests play a central role, since health care services switch from being rights to being market commodities and, in a parallel move, patients become consumers. However, this growing presence of the pharmaceutical companies in Latin America in recent decades is also linked to the emergence of new actors and phenomena in processes of medicalization in the region that are related to the decentralization of practices associated with medical knowledge present in the early stages since “[i]n many developing countries ... where salaries are low and trained Western medical personnel are scarce, [pharmacy clerks, shop owners and medicine vendors] often function as primary sources of health care advice and treatment” (Ferguson, 1981, p.108), decentering, as we saw earlier, the role of the doctor and favoring self-medication and the excessive use of drugs.

A related phenomenon, which is new to Latin America, is the rise and proliferation of a model for marketing low-cost medications that involves similarly low-cost medical care. This model, which emerged in Mexico at the end of the last century, has spread to central and south America and currently has about 3,900 consultation-sales points that, following the principle of facilitating access to primary care for the working class, provide an example of the redefinition of the relationship between doctors and society, “which is trapped between the forces of the State and the market” (Leyva, Pichardo, 2012, p.144). On this issue, it is important to point out that the decentralizing of board-certified physicians does not imply a de-medicalization of the condition for which consultation and/or treatment is sought. On the contrary, the fact that people resort to medical practices and/or knowledge to treat some symptom or ailment independently of the authorized expert – or without dispensing with the expert, but consulting him or her merely to get a prescription in order to gain access to controlled medications – constitutes an indicator of the population’s internalization of the medical gaze and, thus, of the advance of the process.

Medicalization without limits?

The most novel aspect of the changes that began to take place in medicine in the mid-twentieth century, and perhaps the one that most affects its expansion, as some influential theoreticians have stressed (Conrad, 2007; Rose, 1990; Davis, 2010), is that it abandons its previous locus of legitimate action – disease – to extend its influence to health and prevention. There has been a shift away from the disease/cure dyad towards disease/quality of life (Arizaga, 2007), so that the objectives of medicine are no longer limited to restoring health; rather, medicine nowadays is concerned with the individual’s productivity and abilities; incorporating medical knowledge and practices or medications to the individual’s

lifestyle choices; and with not only preventing loss of health but also intervening in the course of natural life conditions such as eating,¹⁷ sexuality (Jones, Gogna, 2012), pregnancy and childbirth (Cecchetto, 1994), menopause (Pelcastre, Garrido, 2001), and aging (Parales, Dulcey, 2002), all of which are starting to be analyzed in Latin America.

While these processes have led some authors to declare that medicalization does not appear to have any limits, in other regions the one-way view of this process has been replaced by a two-way concept which acknowledges that, while less frequent, demedicalization processes can be seen in some conditions. The paradigmatic example remains homosexuality, which in 1973 ceased to be considered a pathology by the American Psychiatric Association.¹⁸

Demedicalization also presupposes a gradation that can occur on different levels.¹⁹ For example, Karen Ballard and Mary Ann Elston (2005, p.238) argue that self-care can be understood as demedicalization in the interactional sense of the term; in other words, a reduction in the use of medical treatments, without automatically abandoning the medical model for explaining health and disease.

The emergence of the topic of demedicalization has led people to question the inexorable nature of its expansion, which is no longer seen as a given but as a problem to be solved. As a result, various opposing views are emerging about its future. According to some, medicalization has already started revealing its limits and there are signs pointing to a progressive demedicalization of many phenomena (Elston et al., 2002). In Latin America, however, the one-directional vision of the process, predicting its expansion, still prevails.

Beyond biopolitics and macroeconomics

Foucault's theses undoubtedly opened up ways of thinking that have revolutionized how the social sciences and humanities posit the relationship between the body and power. Generalizations about biopolitical mechanisms and instruments presuppose an overdetermination of economic and political structures that virtually effaces the agency of individuals and groups. However, when we go beyond the mechanical application of these theses and use empirical approaches that analyze the ways in which individual and/or collective subjects appropriate medicine, the images of passivity and verticality give way to much more complex processes. It becomes clear that medicalized agents are negotiating the norms and resignifying medical discourse; that there is a mingling of biomedical knowledge and other types of knowledge; that certain groups are fighting for medicalization of their ailments; and that the expertise of certified physicians is being disputed. If, as Latour (1987, p.208) claims, "[t]he simplest way to spread a statement is to leave a margin of negotiation to each of the actors to transform it as he or she sees fit and to adapt it to local circumstances," in analyses of the case that deal with the different Latin American contexts, we find evidence of the different ways of negotiating the discourse and medical forms of knowledge, among them:

- (a) "The appropriation of medical knowledge" by medicalized subjects. This appropriation forms part of the broader phenomenon of popular understanding of science, and while it involves the risks involved in incorporating poorly understood health-related discourses and practices into daily life, it also leads to a certain level of democratization of medical knowledge (Collins, Evans, 2007). In this regard, women have played a noticeable role, since they are more likely to consult a doctor and then

to become transmitters of knowledge and even administrators of medication in the context of the family (Observatorio..., 2007).

(b) “Unfinished medicalization” occurs when “historical conditions mean that doctors have not completely gained the necessary cultural authority to exercise total control over issues relating to disease, nor the power to conquer ‘patients’ decisions about control of their own bodies (Platarrueda, 2008, p.189). There are two notable but different phenomena that pertain to this: on the one hand, there is the partial crisis of the HMM and the growing popularity of alternative therapies (Menéndez, 1994). On the other hand, there is the persistence of traditional medicine throughout the great majority of countries in the region, where it has gone from marginalization, which was prevalent during the construction of healthcare systems, to partial integration within frameworks that regulate its practice (Nigenda et al., 2001).

(c) “The emergence of the self-taught patient” made possible by the mass media and literature explaining medical knowledge to the layman. This allows individuals to educate themselves about their conditions, and to participate in forums for questions and discussion, so that their position with respect to their doctors is not one of complete subordination, but allows them to negotiate their diagnosis and/or treatment.²⁰

(d) “The mobilization of individuals and groups” so as to access various types of resources (symbolic, material, or involving social and political organization) that bear witness to their capacity for agency in situations as diverse as suffering from a disease; participating in designing healthcare policies; and belonging to patient and/or support groups (Grimberg, 2002). The diversity of these phenomena affects processes that expand from the identity-formation of given subjects (Lima Carvalho, 2011; Rohden, 2012), to the coproduction of scientific knowledge.

When we consider all these phenomena as a whole, it is clear that while the advance of medicalization in Latin America is undeniable, it cannot be evaluated, as we stated at the outset, without taking into account the many dimensions it involves; and even though one of those dimensions is undoubtedly the normalizing power of the practice and knowledge of medicine, these now constitute rights which people aspire to and forms of knowledge which subjects appropriate in a way that gives them new agency.

Final considerations

The concept of “medicalization” emerged as a critique. This is the first unavoidable proviso when one approaches studies produced in Latin America on the phenomenon or phenomena to which it refers. There is a long-standing and fruitful tradition of critique in social sciences in the region. However, it should be acknowledged that, as in any critique, the tension between description/explanation – evaluation/criticism is present throughout the studies of medicalization in Latin America.²¹ In this sense, these studies continue to be strongly influenced by Foucault’s theses on biopolitics, which often fail to avoid the temptation to apply them without first performing empirical research to show how appropriate they are for understanding processes in the region. However, thanks to the new historiography of medicine (Armus, 2002), studies are beginning to emerge that shed light on the particularities of this multidimensional phenomenon – mostly using qualitative approaches to the data.

The empirical analyses all give a more complex picture of the processes of medicalization, in which the agency of the actors plays an important role in adapting resources and knowledge to what they see as their needs and interests. These processes, like so many others in contemporary societies, involve benefits and risks, but they contradict the complete absence of alternatives in the face of medicine's undeniable power. Thus we can see the complex, paradoxical nature of the process of medicalization, which that can trigger multiple types of consequences and lead at the same time to possibilities, resources and forms of control and self-control. In Latin America, this complex understanding is barely starting to appear in studies of the issue. We still need to analyze the connection between the macro-structures and small-scale phenomena – a problem that is clearly not restricted to this topic, but is definitely seen here – and we need to incorporate newer theoretical tools that will allow analysis of the multiple dimensions involved.

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NOTES

¹ The search for publications on the topic involved the following stages: (1) We did a general search using Google (www.google.com) using the following descriptors [in Spanish]: “medicalization + pdf,” “medicalization + Latin America.” The objective of this initial stage was to identify the journals and platforms whose contents were most relevant to our investigation. We should point out that since this was a “pilot search,” it was not performed in a systematic manner. (2) Based on the results of the “pilot search,” five databases were selected: Red de Revistas Científicas de América Latina, el Caribe, España y Portugal; Scientific Electronic Library Online; Proquest; Citas Latinoamericanas en Ciencias Sociales y Humanidades, and Jstor. (3) Taking “medicalization” as a descriptor, we searched for articles in those databases from March-September 2013. It's important to note that in the case of Proquest and Jstor, the descriptor had to be modified, because the results were not satisfactory. In the case of Proquest, there were no entries under that descriptor. In Jstor, the results were not relevant to our search since they did not comply with our pre-established criteria (see stage 3). Therefore, we used “medicalization” paired with “Latin America” to exclude all those publications not about the region we were interested in. (4) We created an Excel spreadsheet to keep track of the search, showing the date of download and the database where the publications were found. It is important to note that the criteria established for selecting and downloading work were the following: (a) The author had to be of Latin American origin and/or the work had to deal with topics related to Latin America and/or problems present in that region; (b) The text had to be a published article, a book or a book review. Student theses were not downloaded; (c) The word medicalization had to appear in (I) the title of the work and/or, (II) the abstract and/or, (III) the keywords identified for the work and/or, (IV) repeated in the text, or else the concept had to be substantive part of the author's argument. Thus, texts that alluded briefly and descriptively to “medicalization” were not taken into account. We should clarify that our review of the search results was not exhaustive when there were more than one hundred entries found (as in the case of Jstor, Proquest and Redalyc). In these cases, the results were reviewed until they gradually ceased to be relevant to the search (that is, they no longer complied with the criteria in stage 3). In the case of Redalyc, we stopped reviewing after eight hundred entries; for Jstor at two hundred, and Proquest at 120.

² Notable authors from other disciplines who use the concept include Hogle (2002) and Lock (2001, 2004) in anthropology; Nye (2003), Sinding (2004) and Armus (2005, 2002) in the history of medicine; Metzl, Herzig (2007), Moloney, Konrad, Zimmer (2011) and Lantz, Lichtenstein, Pollack (2007) in public health; Thorpe, Philwaw (2012) in economics; Parens (2011) in bioethics; and Lane (2007) in literary research.

³ A highly illustrative example of the expansion of medical jurisdiction is the role of medical experts in criminal trials to determine subjects' innocence or guilt (Campos, 2012).

⁴ The work of Francisco Morales (2010, 2012) shows how fast the leading antipsychiatry texts were translated into Spanish and circulated in our country. These works, however, were not read by psychiatrists. No group of important antipsychiatrists in Mexico ever emerged. Everything seems to indicate that these texts had a much stronger influence in the social sciences. The arguments against mental health care became part of a broader critique of capitalism mounted by the left.

⁵ Foucault later abandoned this position in favor of a more complex view of the process of assimilation and subjectivization of medical discourse that incorporates both self-surveillance and the agency of individuals (Nye, 2003, p.117).

⁶ Medicalization does not necessarily imply the use of medications. It is important to clarify the distinction between medicalization and medicationalization, which is not always made in the literature. Medicationalization refers to the use of drugs as part of therapy. Medicalization, however, refers to processes of expansion of medical jurisdiction, which do not necessarily involve the use of drugs. For example, obesity is a relatively medicalized phenomenon, which can be medicationalized, but can also be treated by diet or exercise (Maturó, 2012).

⁷ Critiques of what was seen as an overestimation of the imperialist capacities of medicine began to appear in the 1970s (Fox, 1977; Strong, 1979). However, it was not until the 1980s that these revisionist views emerged more forcefully in the literature.

⁸ The term hegemonic medical model was proposed by Eduardo Menéndez "to describe the model of medicine that became dominant from the early nineteenth century on, under capitalism; besides basing its exclusive appropriation of disease in law, it privileged a biologist, individualist, ahistorical, asocial, mercantilist and pragmatic view of disease" (Castro, 2011, p.23).

⁹ Self-help groups or support groups have been some of the most proactive in the push to medicalize different types of condition, such as chronic fatigue syndrome (Arksey, 1994; Broom, Woodward, 1996) and pathological gambling (Castellani, 2010). In other cases, for example premenstrual syndrome, discussions were not limited to doctors; feminists, female academics, women's organizations and lay people argued various positions, some accepting the medical nature of the condition and other rejecting it (Figert, 1995).

¹⁰ As an illustration of the promotion of medicalization as a way of overcoming the exclusion of transvestites and transsexuals, something the subjects themselves advocate (Lima Carvalho, 2011).

¹¹ The usefulness of the concept of medicalization is also a factor in designing the agendas of these groups, whether they seek to demedicalize conditions or to medicalize them (Davis, 2010, p.231).

¹² Debates about mental health are a good example of the struggle over who has the authority to define and treat a health problem, as well as the unequal levels of influence held by communities who study this field. For example, Costa Lima, Caponi and Minella (2010) analyze the disputes between psychoanalysis, psychiatry and psychology in Brazil over the formal authority given to their medical professionals as the only ones authorized to treat individuals' mental health.

¹³ We understand that this history is the result of a variety of "works by historians, demographers, sociologists, anthropologists and cultural critics who, from their respective disciplines, have uncovered the richness, complexity and possibilities of disease and health, not only as a problem but also as an excuse or a resource for discussing other topics" (Armus, 2002, p.45).

¹⁴ In this and other citations of texts from non-English languages, a free translation has been provided.

¹⁵ The philosopher of science Philip Kitcher (1996) claims that the contemporary revolution in molecular biology is as profound as the birth of science in the eighteenth century and the achievements of physics in the first half of the twentieth century. It will surely transform the "lives to come" in dramatic ways via its medical applications.

¹⁶ The topic of "medicationalization" has also been examined using the term "pharmaceuticalization," to study the rise of conditions for which the use of drugs is considered appropriate treatment (whether by doctors, patients or both) and in which the pharmaceutical industry plays a leading role (Abraham, 2010).

¹⁷ In this field the practical and symbolic meanings of food are replaced by nutritional values (Gracia Arnaiz, 2007).

¹⁸ Demedicalization can lead to advocacy for certain subjects, as might be the case for people with disabilities (Zola, 1993; Oliver, 1996). However, demedicalization has also led to the recriminalization of other subjects (Ramon, 1986).

¹⁹ Conrad (2007, p.6) argues that we should not see medicalization as a binary process that opts between whether “there is medicalization” or there is no medicalization,” but as a continuum containing a wide spectrum of forms and degrees of medicalization. In other words, not all the phenomena are equally medicalized; some, such as epilepsy, may have been completely medicalized for a long time; others, such as hyperactivity (described as hyperactivity and attention deficit disorder) are almost completely medicalized; others (such as sex addiction) only slightly, and finally some are subject to fierce debate, such as the case of premenstrual syndrome.

²⁰ Steve Fuller (2012) claims that, in relation to scientific knowledge in general, we are currently at a point similar to the Reformation. Just as the Reformation eliminated the mediation of priests in order to access the scriptures, the mass media make possible a redistribution of epistemic power that substantially modifies the relationship between experts and laymen, and nowhere is this clearer than in medicine.

²¹ Our search of publications on medicalization in Latin America showed that the authors, the journals and the topics dealt with in the readings, came largely from Brazil, Argentina and, to a lesser extent, Mexico. This resembles the unequal growth of disease in the historiography of modern Latin America, as identified by Armus (2002), who also points to Brazil as the leading country in the development of this field.

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