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Disease Mongering: How Sickness Sells

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"Disease mongering" is the practice of widening diagnostic boundaries of a disease and promoting their public awareness to expand the markets for treatment and to increase profits. This tactic typically used by pharmaceutical companies, medical equipment manufacturers, insurance companies, and even some doctors and patient groups, has become a great concern. Its start is associated with the 1879 invention of Listerine, when its inventors created an obscure medical condition called "halitosis" to advertise the first over-the-counter mouthwash. Disease mongering has since increased in parallel with "medicalization," which attempts to label normal human conditions as medical problems, thus becoming the subject of medical study, diagnosis, prevention, or treatment. Although some pharmaceutical companies closely follow their industry's codes of ethics, many take advantage of their customers. However, medical professionals hold a greater moral obligation to their patients to do no harm. This paper first seeks to examine how an increasing amount of life's natural conditions and ailments are being seen as medical conditions. This issue may be attributed to the conceptual framework in which a disease is outlined and defined. I will then argue that this alone does not result in disease mongering, rather third parties' attempt to make these conditions seem more serious and widespread than they actually are contributes to the problem. Furthermore, the treatments for these problems are oversold despite sometimes being ineffective or causing more problems on top of the ones they claim to treat. De-medicalization based on respect for human dignity, rather than investor value, is long overdue. The unethical practice of disease mongering can only be combated with joint initiatives from patients, providers, and the general public.

The most foundational question that dominates philosophy of medicine in this generation is: what is disease? This fundamental question encompasses how categorizing disease can depend on the general nature of disease. What arises from asking these kinds of questions has very

practical consequences—how we assess what is or is not considered a genuine disease can impact whether or not health insurance companies cover certain conditions. We believe to know what disease is when we see it and are quick to label cancer or cholera as diseases. However, trying to articulate and precisely define disease is more elusive. This ambiguity leaves open the possibility of blurring the lines between conditions that are serious, undesirable, or just a part of life's natural condition. The conceptual framework utilized to define disease plays an important role in medicalization, which in turn influences the act of disease mongering. Before outlining the different conceptual approaches one can take to define disease, let us consider 3 patient vignettes:

> Tracy is a 34-year-old doctor who was referred to the sleep disorders centers for insomnia, non-restorative sleep, and a feeling of malaise throughout the day. Tracy's sleep problems began during late adolescence and started with difficulty falling asleep. She also developed frequent awakenings throughout the night. She reported that the she experiences a sensation of urgency to move her legs in order to alleviate discomfort. Tracy was diagnosed with Restless Legs Syndrome (RLS) and was advised to decrease her caffeine intake and complete a daily leg exercise regime. These measures did little to decrease Tracy's RLS symptoms. Further investigation concluded that Tracy's RLS was an underlying symptom of her iron deficiency caused by her frequent blood donations. Once she stopped the donation and started taking daily iron supplements her RLS symptoms stopped.[1]
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> Natalia is 41 years old and complains of having low sexual desire since the birth of her children, who are now four and six. She describes her marriage as "fine." The children are not causing problems, and her husband, Daniel, is a good father and a considerate person. Natalia is not clinically depressed, has no history of depression and takes no medication. Her general health is fine, with regular periods. She has a busy part-time job which she enjoys. Natalia denies any spontaneous sexual thinking, need to masturbate or having anything other than the very occasional sexual dream. None of this has changed throughout her adult life. Natalia does not get aroused and expresses no desire to put in the necessary focusing and effort required to reach orgasm. Her working diagnosis points to some kind of sexual dysfunction.[2]
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> Celina is 29 years old and presents to the clinic in distress. During the examination she fidgets and has a hard time sitting still. She has a hard time with time management and tends to be disorganized. She chronically misplaces everyday objects like her keys and runs late to appointment. Although she wants her work to be perfect, she is prone to making careless mistakes. The struggle for perfection makes starting a new task feel very stressful, leading her to procrastinate starting in the first place. Consequently, she has recently

[1] "A Case Study in Restless Leg Syndrome (RLS)." National Sleep Foundation.
[2] Basson, Rosemary. "Women's Sexual Response and." *Canadian Journal* 131 (2001).

> received several warnings from her boss related to missing deadlines for assignments and errors in her work, which has led to her acute fear of being fired. As a child, she received extra time for test taking in school, but never had any formal neuropsychological testing. After some additional assessments, Celina was formally diagnosed with adult attention deficit hyperactivity disorder (ADHD).[3]

The immediate question raised by these case studies is the central dilemma of philosophy of medicine, what is disease? How this question is answered largely depends on what conceptual framework of disease one is willing to accept. A naturalist position argues that disease is a malfunctioning physiological system.[4] Christopher Boorse's biostatistical theory of disease, the most prominent naturalist account of disease, characterizes a disease as "a type of internal state which is either an impairment of normal functional ability, i.e. a reduction of one or more functional abilities below typical efficiency, or limitation on functional ability caused by environmental agents."[5] A naturalist theory of disease holds that if we can locate a pathophysiological basis of a condition, such as Tracy's RLS, Natalia's female sexual dysfunction disorder, or Celina's ADHD, then we can classify them as a disease. On the other hand, a normativist account holds that to call a condition a disease is to hold that a person with that condition is harmed by it.[6] Normativism argues that the concept of disease is value-laden, and claims that the condition is not merely biologically unusual, rather that the condition is bad for people who have it. Essentially, diseases are disvalued states which rely on our own evaluation of those states to determine whether or not a condition is bad for a person. Finally, the hybridist account of disease which serves as a middle ground between naturalism and normativism holds that a disease must involve abnormal physiological functioning and that abnormal physiological

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[3] "Jen (attention-deficit/hyperactivity Disorder)." Society of Clinical Psychology.
[4] Stegenga, Jacob. "Disease." In *Care and Cure: An Introduction to Philosophy of Medicine*, 22–22. The University of Chicago Press, 2018.
[5] Boorse, Christopher. "A rebuttal on health." In *What is disease?*, pp. 1-134. Humana Press, Totowa, NJ, 1997.
[6] Stegenga, Jacob. "Disease." In *Care and Cure: An Introduction to Philosophy of Medicine*, 26. The University of Chicago Press, 2018.

functioning must be disvalued in order for that condition to be classified as a disease.[7] With the conceptual framework outlined, according to naturalism we could only classify Tracy's RLS as a disease, while both normativist and hybridist would classify all three patients as presenting a disease.

Since western medicine overall adopts a naturalist approach towards health and disease, which might suggest that naturalism is the least flawed approach to medicine, I will use this conceptual framework to form the rest of my argument going forward. While one might argue that any of the existing conceptual frameworks used to outline and define disease could very well result in overdiagnosis and medicalization, western medicine's current approach towards disease has encouraged an environment where disease mongering is more prominent in society than ever. It is important to recognize though that in research targeting overdiagnosis, medicalization is often presented in terms of its societal burden of unnecessary medical expansion. The problem with this is that there is a focus that lies solely on the influence of medicine on society, while neglecting the influence of society on medicine. Although overdiagnosis and medicalization go hand in hand, the distinction between the two need to be made.

Overdiagnosis occurs when a person is accurately diagnosed with the pathophysiological basis of a disease, however that pathophysiology would never cause any symptoms within the patient's lifetime.[8] When patients are then treated for the disease it becomes a case of overtreatment. Screening programs can lead to both overdiagnosis and overtreatment which can be a successful tactic used to disease monger. On the other hand, medicalization, as defined earlier,

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[7] Stegenga, Jacob. "Disease." In *Care and Cure: An Introduction to Philosophy of Medicine*, 30. The University of Chicago Press, 2018.
[8] Stegenga, Jacob. "Diagnosis and Screening." In *Care and Cure: An Introduction to Philosophy of Medicine*, 182. The University of Chicago Press, 2018.

is the attempt to label normal human conditions as medical problems. When discussing overdiagnosis and medicalization and its consequences, there is an underlying assumption that classifying medical conditions as a disease and diagnosing these diseases is purely objective, this is untrue. Disease and illness are not merely just biological facts, but social constructions as well. Whether or not disease can be defined as entirely value-free or as unavoidably value-laden can be argued. However, we can agree that values play a large role in the *perception* of disease. Social agents such as government agencies and pharmaceutical companies can impose their values on health institutions through lobbying and policy making or promoting the awareness of diseases and advertising their treatments.

Take for example, the 1879 invention of Listerine briefly mentioned at the beginning of this paper. In 1879, Dr. Joseph Lawrence and Jordan W. Lambert first marketed Listerine as a surgical antiseptic. Before long, its use was quickly spread beyond its original use, to being sold as a floor cleaner and as a treatment for gonorrhea. By 1895, it was marketed to dentist for oral care, and in 1914 it became the first over-the-counter mouthwash in the United States.[9] To further advertise and market Listerine, the Lambert Pharmacal Company in conjunction with advertiser Gordan Seagrove, made up a disease called "halitosis," meaning unpleasant breath, to which their product would "cure." Promoting Listerine as a cure to halitosis resulted in raising the company's total revenue from $115,00 to more than eight million dollars in only seven years.

Consider again the danger of overdiagnosis and medicalization in loosely defining disease, specifically in psychiatry. The Diagnostic and Statistical Manual (DSM), published by the American Psychiatric Association (APA) leaves some forms of mental illness susceptible to

[9] Dossey, Larry. "Listerine's long shadow: disease mongering and the selling of sickness." *Explore (New York, NY)* 2, no. 5 (2006): 379.

disease mongering due to its use of an almost narrative definition of what disease is. Disease mongering expands the boundaries of treatable diseases resulting from strong commercial interest. Consequently, self-diagnosis is also becoming more prevalent in medicine due to the marketing practice of direct to consumer advertising. Think about the mental disorders describes previously in the patient vignettes that are endorsed by the DSM—ADHD and Premenstrual Dysmorphic Disorder. ADHD is the second most common mental health diagnosis, with schoolteachers playing a critical role in the determining who is at "risk" of ADHD in the classroom. This becomes problematic considering that websites funded by pharmaceutical companies are targeting teachers and providing "education" on the diagnosis and management of ADHD.[10] Similarly, December of 2012 marked the approval of the DSM-5, which also approved PMDD to have its own diagnostic category, thus marking PMDD as a mental disorder.[11] Classifying PMDD as a distinct disorder further encourages the marketing of new treatments for the disorder.

Even with all this evidence, some may argue that disease mongering poses no threat to society or medical institutions. If people are being treated for diseases they seem to have, what is so wrong with that? The question that is often posed with any argument is, so what? In a very practical sense, disease mongering results in a battle between private enterprises like pharmaceutical companies and public health. The pharmaceutical industry is a business and operates as such. Their concerns are not geared towards the patients their drugs are supposed to treat, rather the profits that arise from using their drugs as a treatment option. The United States' current Medicare policy prohibits negotiation with drugs companies to lower the prices of their

[10] Saddichha, Sahoo. "Disease mongering in psychiatry: fact or fiction?" *JNMA; journal of the Nepal Medical Association* 50 180 (2010): 320-7.
[11] Epperson, C. Neill, Meir Steiner, S. Ann Hartlage, Elias Eriksson, Peter J. Schmidt, Ian Jones, and Kimberly A. Yonkers. "Premenstrual dysphoric disorder: evidence for a new category for DSM-5." *American Journal of Psychiatry* 169, no. 5 (2012): 465-475.

drugs. This gives pharmaceutical companies free rein over the cost of medication. To put in perspective, in 2018 the total nominal spending on medicines in the U.S was approximately $482 billion, an almost $200 billion increase from 2008.[12] Our partially tax-funded healthcare system simply cannot sustain the increasing cost of drug treatment for all the conditions pharmaceutical companies seek to treat the population. Not only is it concerning that hundreds of billions of dollars are being spent on medication that the average American cannot afford, but some doctors are also in on the game. In 1997, pharmaceutical companies' total spending on marketing to physicians was $15.6 billion, and by 2016, it increased to $20.3 billion.[13] Marketing to physician may include sending paid representatives to doctors' offices to talk about a drug, free samples of drugs, or even compensating physicians for speaking engagements about the drug.[14] While the American Medical Association (AMA) has put strict limits to this, there is still a major conflict of interest that comes from physicians being compensated by pharmaceutical companies for advertising/marketing certain drugs, and if the numbers do not spark any red flags consider the five principles of medical ethics—beneficence, non-maleficence, justice, utility, and autonomy—which are closely related to the two aims of medicine—to care and to cure.

The principle of beneficence is to promote the welfare of others. This is inherent in the patient-physician relationship. Healthcare providers must take positive steps towards helping their patients, which closely relates to the second principle of non-maleficence. The obligation of non-maleficence is to do no harm. While the principle of beneficence is closely related to the principle of non-maleficence, obligations to do no harm are often stricter than an obligation to help. For instance, the obligation to treat an injured or dying person is arguably more important than helping

[12] "U.S. Total Medicine Spending 2002-2018." Statista.
[13] Foley, Katherine Ellen. "Big Pharma Spent an Additional $9.8 Billion on Marketing in the past 20 Years. It Worked." Quartz. January 08, 2019.
[14] Ibid

the needy even if it involves doing a minor harm to a person. The third principle of utility attempts to bring about the greatest amount of good to benefit as many people involved as possible. The principle of justice, also known as distributive justice, states that there should be an element of fairness in all medical decisions. This fairness extends to decisions that burden and benefit. Additionally, there should also be an equal distribution of scarce resources and new treatments. Finally, the fifth principle of medical ethics is autonomy. The principle of autonomy says that people are typically rational, self-determining beings who are capable of making judgements and decisions for themselves and should be able to make these decisions with liberty—free from controlling influence—and agency. Many of these principles are violated by the act of disease mongering. Rather than promote patient autonomy through informed choice and beneficence, the pharmaceutical industry engages in misleading drug advertising and manufacturing new but questionable disease categories like restless leg syndrome or attention deficit hyperactivity disorder. This results in an increase of drug consumption, consequently increasing the risk of harm emerging from inappropriate drug use, which violates the principle of non-maleficence. Additionally, by creating medically unnecessary demands for health-related goods or services, disease mongering worsens the problem of an increasing cost of healthcare, thus violating the principle of justice. It is clear now the issues that arise from disease mongering, the question left to answer is how do we address or combat this?

A key element to addressing disease mongering is education, chiefly educating those who have the ability to confront the primary perpetrators. The influence of the pharmaceutical industry clearly permeates the medical field and consumer advertising. While medical professionals do not have authority over how pharmaceutical companies market and advertise their products, they do have some authority over how they care for their patients. Physicians should not have any financial

ties to pharmaceutical companies and if they do, these industry affiliations should be disclosed and made aware to their patients. Additionally, our paternalistic approach to medicine, where the "doctor knows best," needs to be evaluated. It is common for the general public to blindly accept medical conditions and treatments because of this paternalistic approach. Patients should be encouraged to learn more about their conditions, rather than blindly accept their medical diagnosis. This does not mean that they should be distrustful or skeptical of their doctors, rather educate themselves on the information their physicians are relaying to them and get in the habit of intuitively asking questions. Physicians too, should investigate treatments and conditions that are being advertised and marketed to them by pharmaceutical companies. It is vital that the pharmaceutical industry's role in the development of disease be addressed, and joint initiative from patients, providers, and the general public is crucial to combatting disease mongering.

Disease mongering is largely a result of western medicine's overdiagnosis and medicalization of life's normal human conditions. Pharmaceutical companies utilize this phenomenon to manufacture and promote diseases in order to advertise and sell their drugs as treatments. While it is clear the influence medicine has on society, the influence society has on medicine needs more research since societal perceptions of disease play a role in both overdiagnosis and medicalization. With disease mongering violating almost all the five principles of medical ethics, practical steps need to be taken in order to combat it. Medical professionals should disentangle themselves from the hold pharmaceutical companies have on them. There is a reason pharmaceutical companies spend billions of dollars to educate and sponsor physicians. In turn both patients and physicians should educate themselves as well. If physicians want to continue to truly care for their patients, there needs to be a bigger emphasis on the respect for human dignity, rather than how much profit we can get out of them.

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