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Medicalization of Eating and Feeding

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Introduction

A variety of developments over the past century have produced the conditions in which eating and feeding are transformed from practices embedded in social or cultural relations into explicit medical practices. The rise of medical science, expansion of the pharmaceutical and food industries, escalating concern over diet-related diseases and conditions, and growing anxiety over infant and childhood development have contributed to a process of medicalization.

Medicalization is a sociological concept that analyses the expansion of medical terminology, interventions, or practitioners into areas of the life that were previously considered outside the medical sphere. For instance, under-eating has previously been defined using theological language, as an act of fasting demonstrating a saintly character. Such practices are now understood through medical terms of anorexia nervosa, malnutrition, or general diagnoses such as "eating disorders not otherwise specified." Individuals engaged in under- or over-eating practices are increasingly defined by medical concepts (anorexia nervosa and obesity) and treated in medical spaces (hospitals, clinics, or rehabilitation centres) through medical interventions (pharmaceuticals, surgery, psychotherapy, or dietary regimens). Likewise, infant feeding (breast or formula) is understood as a practice that requires monitoring and instruction from medical practitioners. Further, eating in general is progressively invested with medical significance. Foods and diets are touted as possessing a therapeutic or health enhancing capacity that indicates an individual's or population's present and future health.

Due to the high regard for, and influence of, medical science in the West, medicalization studies primarily focus on Western contexts. Medicalization does have an impact on non-Western societies and the developing world, however its influence emanates from Western biomedicine, industries, and policies. There is important work to be done in examining the process of medicalization in non-Western contexts, however this article is limited to the Western context (Hunt, 1999).

To analyse the medicalization of eating and feeding it is important to first sketch the theoretical and historical background of medicalization as a sociological concept. The relationship between eating and medicine is extensive. In order to focus the discussion, three examples are used – under-eating, over-eating and infant feeding. This background focuses the analysis of the forces driving the medicalization of eating and feeding. Finally, in elaborating the influences and consequences of the medicalization of eating and feeding, some of the central ethical implications are identified and discussed.

Background

The concept of medicalization developed out of the anti-psychiatry critique in the 1960s. Thomas Szasz's *The Myth of Mental Illness* (2010), originally published in 1961, argues that psychiatry obscures the social with the psychological, transforming social behaviours and problems into symptoms of diseases that

require medical intervention. According to Szasz, mental illnesses such as schizophrenia or attention deficit hyperactivity disorder are medical creations that mask the social problems individuals experience, and justify coercive medical treatment. The work of Michel Foucault, Ivan Illich, Irving Zola, and Peter Conrad has been influential in advancing the concept of medicalization.

Philosophical debates over medical epistemology (theories of knowledge) play an important role in critical and ethical analysis of medicine (Stempsey, 2006; Schwab, 2012). Medicalization is associated with social constructionist theories of knowledge (Conrad, 2007). Rather than contending the existence of a biological or pathological reality, medicalization studies argue that complex, yet contingent social and cultural forces determine certain medical knowledge, categories, and definitions. Importantly, the social constructionist theory of knowledge does not argue that the phenomena described by medical categories are merefictions, but that the medical categories are artificial constructs that misrepresent social phenomena as biological or psychological pathologies. This is evident in the example of under eating and anorexia nervosa.

Under Eating and Anorexia Nervosa

Anorexia nervosa is an important case of the medicalization of eating, and also demonstrates that the social constructionist approach does not minimize or trivialize the phenomena that are medicalized. Critics of the medicalization of anorexia do not discount the health implications of under eating, extreme weight loss, or food refusal (Bordo, 2003). However, they argue that reducing the reality of anorexia to the biology or psychology of the individual excludes the influence of social and cultural norms of the body, beauty, and femininity. Rather than isolating anorexia and under eating as medical phenomena abstracted from society, critics argue that anorexia and under eating need to be understood in the socio-cultural context in which they arise.

The relationship between hysteria and anorexia is helpful in elaborating the social constructionist account of medicalization. In the nineteenth century, hysteria was considered a meaningful medical diagnosis for women, demonstrated by an array of symptoms such as nervousness, increased or decreased sexual desire, food refusal, disobedience, or sleeplessness. Medical practitioners treated women who exhibited these symptoms through a variety of methods supported by highly esteemed research and evidence. However, by the twentieth century hysteria was no longer recognized as a legitimate medical diagnosis. Some of the symptoms came to be regarded as the result of coercive social norms of femininity, while others were reframed as evidence for other conditions such as schizophrenia and anorexia (Brumberg, 2000).

Establishing a psychological and/or biological cause for under eating and anorexia justifies medical interventions into the practice of eating. Through cognitive behaviour therapy and medical nutrition therapy, medical professionals attempt to intervene in the psychological factors affecting eating practices. Using strategies such as food diaries and meal plans, medical professionals seek to control eating behaviour in accordance with medically determined norms. In life threatening situations techniques such as forced or intravenous feeding can be employed. The implications of these interventions and the transformation of eating from a social and cultural practice into a medical act are discussed further below.

Over Eating and Obesity

Since the middle of the twentieth century large body mass has been viewed as medical problem and defined through medical terms such as obese or adipose. Over-eating is regarded as the primary cause of large body mass, and therefore targeted by medicine. Importantly, medicalization is not an absolute process. Medical language and practices do not completely exclude moral, theological, or legal perspectives. Moral descriptors such as gluttony and weak-will remain entangled with medical conceptions, however these terms are increasingly recast through medical language, such as "hyperalimentation", "binge eating disorder", or "night eating syndrome".

The medicalization of eating in the context of obesity relies on a mechanistic conception of physiology. Energy intake (food) needs to balance with energy expenditure (exercise). Too much eating with too little exercise creates an energy surplus that leads to an increase in body mass. Obesity is commonly determined by the body mass index (BMI), which divides an individual's body mass by the square of his or her height.A BMI greater than 30kg/m^2 is defined as obese. Not considered a disease itself, medical professionals regard obesity a risk factor for diseases such as diabetes, heart disease, and types of cancer (Gard and Wright, 2005). While there is a focus on increasing exercise, altering eating practices is regarded as the most obvious way to treat obesity. By creating a causal chain from eating to obesity to disease, medicine seeks to control eating practices as a means to control disease.

A number of medical interventions have been developed to control eating practices. Surgical interventions include jaw wiring (resulting in a liquid diet), intestinal bypass surgery (reducing the absorption of calories), gastric bypass surgery (reducing the size of the stomach and the volume of food it can hold), and gastric banding (implantation of a medical device to reduce the size of the stomach). These procedures enable medical control over the form, absorption, volume, and frequency of eating (Sobal, 1995). Each procedure has a range of significant complications, such as malnutrition, anastomotic leakage, gastric dumping syndrome, infections, and incisional hernia. In addition to surgical interventions, pharmaceutical solutions have been sought to alter eating behaviors by producing the feeling of satiety and the suppression of appetite.

The use of direct surgical or pharmaceutical interventions is increasing, however the most common treatment to change an individual's eating practices, and thereby reduce body fat, is through dieting. Dieting ordinarily occurs away from medical professionals and outside of medical spaces (clinic or hospital), yet they are imbued with medical significance and often supported by medical professionals. The increase of the medically prescribed or validated diet for obese and non-obese individuals suggests a general medicalization of eating (Sobal, 1995). Through meal planners, food diaries, or commercial weight-loss programs that offer meals created by nutritionists, eating is reframed as a medical practice that either fortifies health or increases the risk of obesity and disease.

The validity of the energy intake/expenditure conception is disputed from a variety of perspectives (Gard and Wright, 2005). Some critics accept that obesity and over eating is a problem but argue that it is a social problem with causes located beyond an individual's eating practices. These critics focus on social and environmental factors, such as urban planning and the increased availability of highly processed foods at the expense of fresh foods. At the other end of the spectrum, critics argue that the medical significance of body mass and over eating is exaggerated. They argue that individuals process and use energy at different rates and that larger body mass is not an indicator of over eating or disease but human diversity (Rothblum and Solovay, 2009; Bacon, 2010).

Infant Feeding

Infant feeding (formula, breast, or bottle-fed breast milk) has also been brought under the guidance of medical knowledge and practitioners. The vulnerability of infants and perceived long-term health impacts of infant feeding produces impassioned debate over the best feeding practice. The medicalization of

infant feeding occurred with the development of paediatrics as a medical speciality and an emphasis on scientific motherhood from the 1840s onwards (Apple, 1987). Prior to this, infant feeding was largely within the domain of mothers and midwives. Under these circumstances breastfeeding was the norm with rudimentary and unreliable substitutes used under particular circumstances.

During the 1840s the infant-food industry began producing infant formula and advertising their products in medical journals and women's magazines as a healthier and more convenient alternative to breastfeeding. Recognising the commercial and medical significance of formula, medical researchers began working alongside and in competition with the commercial sector to enhance formulas. This period also saw a shift in childbirth from the home to the hospital. With childbirth occurring in hospitals, medical practitioners and paediatricians assumed control over infant health and encouraged mothers to use formula for its healthfulness and scientific basis. Mothers choosing to breastfeed were advised to supplement breastfeeding with formula to ensure the infant's health (Apple, 1987).

It is important to note that formula is not the medicalization of feeding, with breastfeeding is as a non-medical practice. The emphasis on the medical benefits of formula implied the medical insufficiency of breastfeeding. The reemphasis on breastfeeding that occurred during the late 1970s mobilized medical evidence to counter arguments that breast milk is inferior to formula. Extensive lists of health benefits of breastfeeding were published in magazines, medical journals, and popular books, claiming that breastfeeding protects against diabetes, asthma, and obesity and that it increases an infant's IQ (Wolf, 2011). Further, research into the potential for diseases, toxins, and alcohol to transfer to an infant through breast milk did not dampen enthusiasm for breastfeeding, but has led to medical professionals monitoring mothers to ensure that an appropriate diet and necessary care is used. Controversies over both formula and breastfeeding are part of, and contribute to, the process of medicalization of infant feeding (Van Esterik, 1989).

Forces of Medicalization

Early critiques of medicine, notably Ivan Illich's *Medical Nemesis* (1975), argue that medical institutions and practitioners drive the process of medicalization. Illich argued that the imperialist expansion of medicine to all areas of life – from birth to death – allows practitioners to control, dominate, and direct the lives of individuals. This thesis has provoked a counter accusation that critics of medicalization are given to conspiracy theories and 'doctor bashing' (Conrad, 2007). The extent to which nineteenth and early twentieth century medicine sought to control life is debatable, however it is clear from recent examples that medicalization has been driven by forces that do not fall exclusively within the domain of medicine. The forces that have promoted the medicalization of eating and feeding include, but are not limited to, professional medical organizations, advocacy groups, private industry, government policy, and the media.

National and international medical organizations have significantly influenced the process of medicalization. For example, the American Psychiatric Association and the World Health Organization produce diagnostic manuals that shape the definition of disease and influence policymakers, clinicians, researchers, insurance companies, and pharmaceutical companies. Conditions such as hysteria, homosexuality, masturbation, obesity, erectile dysfunction, and attention deficit hyperactivity disorder have been included or removed from such manuals over the past fifty years, arguably due to non-medical influences (Conrad, 2007).

Consumer and patient advocacy groups are increasingly influential forces on medical research and the medicalization of eating and feeding. Advocacy groups use public awareness campaigns, lobby policy makers, and provide research funding to increase the profile of an existing condition or to promote a condition or practice not yet recognized as medical. For example, the La Leche League International and

the National Alliance of Breastfeeding Advocacy raise awareness about the health benefits of breastfeeding and campaign for policies to encourage breastfeeding (Wolf, 2011). A variety of other advocacy groups foster public understanding for diet and eating related conditions, such as the National Association of Anorexia Nervosa and Associated Disorders, Obesity Action Coalition, or National Foundation for Celiac Awareness.

Advocacy groups are also influential in the de-medicalization process. In response to obesity, the National Association to Advance Fat Acceptance and the Fat Underground critique the medicalization of over eating and advocate for the acceptance of body diversity (Rothblum and Solovay, 2009). These groups draw on the exemplars of the Gay Liberation Front and the Gay Activist Alliance, who were instrumental in the removal of homosexuality from the 1974 edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*.

Industries also play a significant role in the medicalization of eating and feeding. The food, weight-loss, pharmaceutical, and insurance industries all play distinct, yet overlapping roles. For instance many pharmaceutical companies own the medical devices used in gastric banding. It is profitable for these companies, as well as the surgeons and clinics, if more surgeries are performed. However, health insurance companies often limit cover to surgeries for medical rather than cosmetic need. Therefore the medicalization of obesity, and the control of eating practices as a treatment, is promoted by a network of actors. These include advocacy groups (Obesity Action Coalition), pharmaceutical industry representatives (Johnson & Johnson), and medical organizations (American Society of Bariatric Surgery) (Conrad, 2007). The food industry is also an important force in the medicalization of eating. While food companies are careful not market products as pharmaceuticals, there is an increasing trend to market products with health claims, blurring the distinction between food and medicine. This process transforms the act of eating from a pleasurable or social act into a medical and health-benefiting act.

Government awareness and public health campaigns drive shifts in the way conditions and practices understood. For example, the U.S. Department of Health and Human Services' National Breastfeeding Campaign from 2004 or the many campaigns around the Western world targeting over eating and obesity have promoted medical conceptions of eating and feeding practices. These campaigns attempt to alter public perception of eating and feeding and raise awareness of the medical relevance of such practices.

The media are enormously influential forces, yet difficult to quantify. From reports on food safety scares to the importance of super-food, the media (in their increasingly varied forms) shapes public understanding of the medical significance of eating practices (Lupton, 1996). The media helps to popularize nutritional research as well as introduce the public to terms such as omega-3 or folic acid. The media are used by, and amplify the impact of, the forces described above.

Ethics and Consequences of Medicalization

The analysis of medicalization can be a purely descriptive task. A study examining the medicalization process may attempt to describe shifts in the way a condition or practice is understood and refrain from valuing one understanding over another. However, the majority of research into the process of medicalization adopts a critical stance. The transformation of social or cultural phenomena into medical conditions is often considered to have harmful consequences for individuals and society. However, some scholars suggest that medicalization produces both positive and negative consequences (Purdy, 2001; Parens, 2011). Considering the potential for medicalization to produce mixed consequences, philosophical and bioethical analysis of the process is needed (Sadler et al., 2009). The examples above demonstrate a number of consequences that require ethical consideration. Consequences vary between conditions, practices and the socio-cultural situation in which they occur; yet a number of common consequences can be isolated.

First, the lives and practices of women are disproportionately medicalized (Bordo, 2003; Conrad, 2007). Women are burdened with the responsibility to ensure their own eating practices accord with medical direction, but they are also positioned through the forces of medicalization as responsible for the eating and feeding practices of infants, children, and partners. While medical authorities target certain eating practices of men, particularly in relation to obesity, male over eating is often regarded as an indicator of masculinity.

Second, the process of medicalization obscures socio-cultural contingencies. In treating under eating and anorexia as a medical condition, the analytic lens is focused on the biological and psychological. This focus excludes the influence of social and cultural norms on eating practices and perception of the body (Bordo, 2003). Ironically, failure to acknowledge the influence of norms of femininity and the body has consequences for health, as the foundational causes are not addressed. The failure to critique social and cultural norms also has implications for the just and fair ordering of society.

Third, in framing problems such as under eating and anorexia as a pathological condition of the individual, medicalization has an individualizing effect. Instead of addressing harmful social norms, political discrimination or environmental factors, and critiquing those that promote them, medicalization reduces the cause of a particular phenomenon to a blameless and morally neutral pathology. Positioning the individual as sick can be beneficial as it reduces individual responsibility and stigma, particularly when an individual is suffering from a biological pathology. However, if the 'disease' is social, or entangled with the social, rather than biological or psychology, then focusing on the individual also removes responsibility from societal and political influences.

Fourth, medicalization can remove stigma and limit individual responsibility for a problem, however it can also reinforce and amplify individual responsibility and choice. Rising concern over the ramifications of the perceived 'obesity epidemic' has lead to eating practices and the bodies of people defined as obese to be characterized as irresponsible (Gard and Wright, 2005). The amplification of individual responsibility and choice is also evident in the medicalization of infant feeding. Mothers' feeding decisions are positioned as evidence of responsibility (or irresponsibility) and determiners of the long-term health of the infant (Wolf, 2011). In these instances, medicalization burdens individuals with the responsibility for outcomes that are not necessarily within the individual's control or choice. This scenario raises deep philosophical questions of moral responsibility for actions partly determined by uncertain or uncontrollable factors (Nagel, 1991).

Fifth, medicalization enables medical control of aspects of life that do not require control. The fat acceptance movement argues that bodies medically defined as obese are instances of human diversity, like height and eye color. Further, they contend that people with a larger body mass do not necessarily eat more than people considered to have a normal body mass (Rothblum and Solovay, 2009). From this perspective, medical control and surveillance of eating as it relates to body mass is unnecessary and harmful, especially when irreversible surgical interventions are employed.

Sixth, increased medical surveillance over daily life is a substantial consequence of medicalization. Examples can be home-visits from dieticians and nutritionists to ensure medically appropriate meals are prepared, or the use of nurses to monitor infant development and instruct mothers on how to care for their child in accordance with best medical knowledge (Apple, 1987). The provision of medical assistance is an important part of a just society. However, if assistance is provided for non-medical conditions, the medicalization of these conditions can reduce individual autonomy and create an unnecessary dependence on medical authority.

Finally, in addition to the effect on specific practices and conditions, the medicalization of eating as it relates to dieting and health promotion can transform eating and feeding from a social and cultural practice into medical therapy (if the individual is ill) or enhancement (if the individual is well). This shift disrupts and transforms relational and communal activities, such as the meal and food preparation, into

medical acts. Further, in magnifying the medical effect of eating practices on the future health of an individual or infant, the medicalization process has the potential to produce anxiety and unease without the necessary evidence to support claims about the future effect of eating practices on health.

Summary

The medicalization of eating and feeding is a process through which eating and feeding practices are transformed from social and cultural phenomenon to medical acts. The process of medicalization occurs through political, social, and medical contingencies that shape human behavior and interpret certain practices or conditions as causes or symptoms of disease. The examples of under-eating, over-eating, and infant feeding demonstrate the complex web of influences involved in the medicalization process. A number of ethical concerns result from this process, including the reduction of culturally significant practices to medical ends, gender inequality, masking social injustice, obscuring social and environmental determinants of health and disease, burdening individuals with responsibility for conditions beyond their control, and increased medical surveillance.

Cross-References

Functional Foods

Dieting and Weightloss

Obesity

Health Claims and Consumer Policy

Food/Body

Food addiction

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