A definition of medicalization my colleagues and I presented to the bioethics community in 2009 was “Medicalization describes a process by which human problems come to be defined and treated as medical problems” (Sadler et al, 2009, p. 412). The AMA House of Delegates resolution to declare obesity a disease in May of 2013 may well be the most profound act of medicalization in American medicine, if its significance is measured by the numbers of people affected by this decision.

Moreover, obesity represents the latest example of what might be called ‘risk–factor’ medicalization. Risk–factor medicalization is that version of medicalization which declares as disease those conditions that put someone at a probabilistic risk of (another) illness or injury. The classic example in internal medicine is hypertension, in which, as Arthur Kleinman puts it (1991), one has a disease but is not sick. For people who meet the diagnostic cutpoints for hypertension, they may feel perfectly well but in Medicine’s view they must undergo treatment for a condition that could lead to stroke, heart attack, kidney failure, or worse. Hypertension is a risk factor disease—a condition, which contributes probabilistic risk for other diseases or injuries.

The American Psychiatric Association, in its deliberations on DSM–5, provoked vigorous debate about another example of risk–factor medicalization, Attenuated Psychotic Disorder (Tsuang et al, 2013), which was a relatively benign behavioral condition correlating with the development of a first episode of schizophrenic psychosis. What made the proposed category so controversial was the prospect of putting large numbers of adolescents at–risk for Schizophrenia on preventative antipsychotic medication, the latter being a risk factor for a ‘metabolic syndrome’, including obesity! One problem with risk–factor medicalization (RFM) is that prescribing interventions for at–risk people...
exposes them to risks, perhaps unforeseen risks, of the selfsame treatments intended to avert or diminish the future unhealthy consequences. The search for a pharmaceutical solution to obesity has led to a number of drug treatments that were far worse than obesity—remember “fen-phen”? (Fishman, 1999; Mundy, 2010). Preventative treatments implied by risk-factor medicalization categories introduce complex and speculative risk-benefit tradeoffs, often with limited information and prediction of desirable, undesirable, and unforeseen consequences. Lauren Moore notes:

Sometimes a treatment with weight loss side effects is given to me; and its use encouraged despite other side effects being so harmful that it’s better to live with the original problem. When I was offered Metformin for my Polycystic Ovaries, my reaction to it was so severe as to cause me to throw up all my meals, go through frequent dizzy spells and deal with chronic stomach pain. My doctor advised me to stick with the tablets, because it seemed that I was losing weight. My pain did not seem to be a factor.

A second problem with RFM has been identified in Sara Jordan’s essay as the issue of “fit but fat”. How does a clinician regard a RFM condition in terms of applying the future concerns to a unique, individual patient? Medical–scientific disease knowledge is almost always population–based, probabilistic knowledge: people with condition X have a so–many percent chance of something undesirable happening. Because medical knowledge is probabilistic, the conditions and people who fall outside of the probabilities are likely to be treated like Jordan. Patients are too often counseled from the safe–bet perspective and not the unique–singular individual perspective. Multiple authors of these essays lament the one–size–fits–all approach of their doctors, feeling dehumanized as well as stigmatized. Sarah Bramblette’s pulmonologist makes hasty assumptions:

“I knew your problem before I even saw you, all I needed was to see that you weighed over 300 lbs to know why you are short of breath” was the greeting I received as the pulmonologist walked into the exam room. He had not even fully read my medical history or examined me and had placed the blame for my problem on my weight.

Similarly, Judith Bruk’s PA is sure that obesity is never a hormonal problem, Jennifer Hansen’s obstetrician confabulates her case of gestational diabetes, Lauren Moore’s doctors take one look at her and sees diabetes and hypertension that she doesn’t have, Roberta Price’s doctors miss her hormonal problems, and so on. We medical educators are evidently doing a bad job of educating doctors to not overgeneralize population data into judgments about individual people. We should do better in helping doctors understand the limits of probabilistic, population–based reasoning.

A third problem with risk–factor medicalization, less evident in these essays, is the problem that RFM makes for a potentially limitless number of ‘diseases’, because of the many risk factors associated with, and predicting, health outcomes. The potential expansion of RFM categories is limitless. Moreover, this potential raises the issue of why some RFM categories qualify for ‘disease’ status, and some don’t. On what criteria does one decide that this risk factor warrants recognition as a disease, and that factor does not? This was one of the reasons the AMA’s own Council on Science and Public Health recommended against declaring obesity as a disease (Conover, 2013). Being an adolescent puts one at high risk for accidental injury. Does that make adolescence a disease?

Medicine and the medical–industrial complex in the USA needs new ways of thinking about and acting regarding risk factors, instead of declaring them diseases. One possibility is a health–promotion approach to risk factors, illustrated here by the comments about Weight Management Specialists and the like by Judith Bruk and Anonymous One. A focus on health promotion makes a lot of sense, but the problem with these approaches in the US is the general problem of funding preventative health care: it does not conform to the disease–model of insurance company reimbursement, and often isn’t reimbursed. Judith Bruk comments:

It means it [obesity] is a disease for which one’s primary care physician seems comparatively under qualified to prescribe or test for, where the few specialists that do exist are not covered by
insurance, and whose symptoms are regularly treated as a moral failing instead of a complex cascade of interacting conditions that vary greatly from individual to individual.

Insuring preventive care depends upon actuarial risks of long-term benefits. That is, the insurance company stands to gain with preventive care only if the insured individual remains in their system for decades, in order to secure the cost-savings of reduced disease morbidity in the years to come. Here, the American system of employer-based insurance makes insuring preventive care a losing game for insurers. In the current American health care system, chances are the employee or insured will move on to another company, robbing the insurer of the diminished morbidity provided by preventive care. Only time will tell how the Affordable Care Act will influence the long-term utility of preventive care.

So much for risk-factor medicalization. Another focus of this commentary is on the hubris of doctors and other healthcare professionals as revealed in nearly all of these essays. Clinicians read here as callous, overgeneralizing, arrogant, and too often, incompetent; missing important obesity-related medical conditions: thyroid disease, polycystic ovarian disease, insulin resistance, etc. Jennifer Radden and John Sadler have written elsewhere (2008; 2009) about virtues in clinicians. I have privately wondered if ‘humility’ is among the most commonly absent of clinician virtues. These essays have done nothing to dissuade this impression. My earlier discussion of the limits of probabilistic reasoning is only a partial explanation of the insensitivity exhibited by most of the clinicians in these essays. Another contribution is surely the bald hubris of sweeping assumptions, unfounded generalizations, and thoughtless suggestions such as this one from Christine R. Brass:

In the middle of an annual pelvic exam, the gynecologist said to me, “You should apply to be on ‘The Biggest Loser.’” I was too stunned and embarrassed to mutter anything more than a comment that I didn’t think that, being quite introverted, I was a good candidate for a reality TV show. She argued with me about that. I felt blindsided, intensely vulnerable, and dumbstruck—completely unable to respond—and later, when the shock wore off, incandescent with impotent rage.

But as psychiatrists are wont to do, I should look behind these clinicians’ offensive veneer and try to understand the vulnerability behind the hubris. One needn’t look too hard to find the source—helplessness—evident from these essays as well as the discourse about the AMA declaration of obesity as disease. Conover (2013) in his Forbes report on the AMA decision notes one of the rationales for the AMA declaration is to promote the development, testing, and implementation of obesity management programs, which at present are offered to a minority of individuals with obesity (see also AMA 2013). The 2013 AHA/ACC/TOS Guideline for the Management of Overweight and Obesity in Adults (Jensen et al, 2013) makes lifestyle management recommendations, which in large part depend upon Trained Interventionists who are largely absent from most healthcare clinics and practices today and whose reimbursibility has been limited at best (Conover, 2013). My conclusion is that too often clinicians mask their helplessness in helping their obese patients by bravado, cajoling, and shaming, all unfortunately ineffective with the problem—as our authors demonstrate.

Declaring obesity a disease is an interesting social experiment in policy and service delivery change. Let’s hope that the AMA succeeds in generating credible, affordable options for this complex problem, enabling doctors to be more helpful and professional.

References


