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# THE MEDICALIZATION OF RISK

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**Abstract**

The medicalization of risk, which has become an idol for some, misleads contemporary society about the true purpose of life and the capabilities of medicine to provide health and eternal life. Preventive medicine provides countless strategies to medicalize risk, that is, to treat the risk of possible illness and death as a medical problem requiring medical solutions. Pharmaceuticals have become a powerful force in modern culture being consumed to alleviate human suffering, modify vulnerabilities, and reduce the risk of future morbid events.

The church did not argue whether drugs were intrinsically bad or sinful, but they considered it a problem when a real good is turned into an idol. Idolatry not only endangers man's relationship with God, but also disrupts human relationships. This leads to the obsession with obtaining good health and at the same time the fear of a possible illness, without any objective basis for this.

**Keywords**: medicalization, risk, ethics

## Introduction

If at the beginning of the COVID-19 pandemic, bioethicists focused in particular on the issue of rationing ventilators and other medical resources in conditions of shortage, later their attention turned to the risk of illness and death due to this infection. Hence the many disagreements about mask wearing, social distancing, lockdowns of all kinds, government spending, isolation of those infected with COVID, vaccine testing and vaccination schedules, clinical strategies, idiosyncratic drug reactions, etc.

The differences over the infection with COVID-19 have divided even the Christian believers, to whom, in efforts to mitigate the epidemiological risk, the authorities have suggested that they no longer participate in religious services, that the clergy do not visit the dying, and the spoon for administering Holy Communion should no longer be used.

Although decisions to allocate resources and preventive measures have been described as being based on "*objective medical evidence*," bioethicists argue that this is not entirely true due to the significant amount of unreliable information that has been accepted as evidence. In addition, often unrecognized social value judgments were used (Ryan, 2022).

Preventive medicine offers many strategies to medicalize risk, but bioethicists question whether or not these are ethical, especially when they are transformed and perceived as an idol.

## Risks and distributive justice

At the beginning of the 19th century, when the French Civil Code was promulgated, the supreme philosophy of responsibility reigned: each person is responsible for his own fate. Unable to offer satisfactory solutions to the great challenges that industrialization raised, societies found, in the philosophy of risk and the institution of insurance, more suitable instruments for governments, giving birth to what we call, improperly, the "*welfare state*". However, this constitutes a drama of political reason: if private or social insurance had the effect of multiplying cases of responsibility, but also a denial of responsibility, it means that

societies have definitively given up governing themselves according to the principle of freedom (Ewald, 1986).

According to distributive justice, within the risk paradigm, resources are to be distributed equally, provided reparations go to those most affected. For example, post-pandemic health care labor disputes relate to the risks of doctors and medical staff. But in order for people to judge the dignity or merit of others, altruism, or even a personal interest, is needed, both with the role of supporting redistributive welfare. In most cases, these social justice attitudes stem from a larger framework of ideas that relate to popular wisdom about the role of effort and wealth in people's lives, or the value of self-discipline versus self-expression (Lamont, 2000). This perspective suggests that attitudes toward common redistribution in a society are rooted in a broader set of institutional frameworks that organize their incentive structures, but also in cultural frameworks related to the cognitive, symbolic, and normative repertoires that people use in decisions regarding their lives.

The concept of "*successful societies*" refers to that society that improves people's capabilities to achieve important goals to their own existence, either through individual or collective action. The link between health indicators and "*successful societies*" is expressed by the term "*health plus*", which encompasses many positive phenomena associated with good health, such as equality, inclusion, democratic participation, a satisfying job, a functioning family and so on. Such an extension of the concept of health to its social components is certainly desirable, and "*successful societies*" are certainly those which tolerate a plurality of cultural standards for measuring the worth of persons belonging to different social groups (Hall & Lamont, 2013).

There are situations where fears about health risks can undermine social relations at the interpersonal level when the other's presence is perceived as a threat, and the Covid-19 epidemic is suggestive: Looking cautiously at the person passing by on the street to see if he is wearing a mask; some, though at a distance, became enraged at the sight of groups of people irresponsibly gathered on the beach; others were outraged by the footage of the protesters. All this was interpreted as a possible recurrence of an infectious outbreak. The same could be said of environmental concerns, such as the ruling on those who drive large cars, people who don't recycle, and other situations that contribute to the risk of catastrophic climate change.

We can extend fears of others' contribution to increased risk to judgments about behaviors that affect the other's health. Here, for example, is the anger directed against the obese. By increasing their risks for diabetes, cardiovascular disease, etc., they change the social distribution of risks, which ultimately translates into increased costs, which are distributed throughout society through the insurance system, thus placing unfair burdens on others (Scherz, 2023). These disputes in which the other is seen as a source of danger lead to institutional controversies that can undermine the possibilities of joint action. This is why culture and education, which represent the variables in the equation that link the socio-economic health circumstances of the population, must be viewed with great responsibility by public authorities, but also by civil societies because they could be an impetus in the provision of medical assistance effective and non-discriminatory.

**The paradigm of risk**

In the fumbling of epidemiological measures during the COVID-19 pandemic, there were situations where, under the pressure of parents, students and some teaching staff, the authorities were forced to reopen schools and university campuses, thus creating, in the opinion of some, risks unacceptable viral spread, apparently giving priority to immediate social problems, but also to financial systems.

If opponents of reopening schools raised the issue of the possibility of a child dying from COVID-19, supporters of the decision brought up the long-term consequences of lower educational attainment and mental health problems due to isolation.

The battles over acceptable risk do not only arise in relation to the infection of COVID-19, but underlie many political questions: environment (appropriate risk thresholds for toxins or carbon dioxide emissions), war (whether there are risks that justify preemptive strikes) , criminal justice (risk of crime vs. risk of incarceration, police violence), vaccines (risk of side effects vs. risk of infection), etc. These conflicts signal the emergence of a new governance paradigm, called the "*risk paradigm*". By the risk paradigm, we mean "*a particular way of looking at problems*"; that is, hazards are seen through a "s*tatistical and probabilistic technique, whereby a large number of events are sorted into a distribution*" (Scherz, 2023).

Primum non nocere, first do no harm. All countries are faced with the problem of environmental pollution, but in different dimensions. At least until now, the most developed were the ones that polluted the most, and the pollution, through natural and economic circuits, became generalized. The less developed countries, although they have a smaller contribution to pollution, suffer more because they do not have the necessary resources for prevention and depollution actions. Romania is recognized among the countries with serious problems in this regard. Pollution, however, greatly diminishes reproducible natural resources and, in addition, is a serious danger to health, which increases expenses for this purpose. According to some calculations, over 60% of the planet's population is affected by insufficient medical care.

Regarding acceptable risk in medicine, benefit risk scores, diagnostic, prognostic and therapeutic criteria or scales are useful in daily activity, leading to the saving of time that is very precious for the patient, the results of the medical act, but also the reduction of costs.

If some validated scores such as CHA2DS2-VASc (Calculates the risk of stroke for patients with atrial fibrillation) or HASBLED (Estimates the risk of massive bleeding in patients with atrial fibrillation and undergoing anticoagulant treatment) are very useful in therapeutic decisions, those of emergency medicine or neurology facilitates the decision to admit a patient or not, to perform an imaging technique or not. Prognostic scores with applicability, especially, to patients in intensive care units are very important in medical practice, having the role of imposing closer surveillance and aggressive therapy. There are also clinically unvalidated risk scores that can be the source of prospective studies.

Because curative treatments are expensive, medicine uses interventions such as screening programs (cancer, genetic diseases, metabolic diseases, cardiovascular diseases, etc.) to prevent them or catch them at an early stage of disease. Preventive medicine thus changes the social distribution of disease risk as well as its global incidence. Another method used to reduce the risk is the administration of drugs, which stop the progress of the risk of diseases such as: blood pressure, arteriosclerosis, diabetes, etc. The accusations against drugs, however, relate to five main factors: firstly, the drugs are, in the great majority, ineffective: secondly, also in the great majority, they are dangerous; thirdly, they are in a permanent metamorphosis, a fact that generates confusion and mistrust; fourthly, it encourages overconsumption; fifth, they are expensive, which creates suspicion for the commercial interests behind them (Percek, 1981).

As for the side effects of drugs, they are often overlooked because certain risks such as myocardial infarction or stroke become visible while others such as low blood pressure may go unnoticed.

The visibility of risks is determined by cultural and historical factors in a community. For example. the risk of myocardial infarction has become visible due to the popularization

of large clinical trials funded by pharmaceutical companies, support groups for these patients, cultural impact through mass media, sudden cardiac death and resuscitation attempts, etc.

A strategy used by public support groups (advocacy) for a particular cause is to flatten the real variability of a phenomenon. For example. While high blood pressure affects middle-aged men, who otherwise have a long life expectancy and few other immediate health risks, it poses fewer risks to older people who frequently have many of the conditions that can intersect with the side effects of high blood pressure medicines. However, these differences disappear when the two levels of risk are flattened into a single risk for the population as a whole. In the created situation, hypertension is considered a serious condition that requires treatment for all. This is the policy of pharmaceutical companies that constantly seek to expand their market to the widest possible level of the population, despite diminishing benefits for those affected. In other words, the risk can be taken to infinity, resulting in increasingly disproportionate costs (Kaufman, 2015).

Preventive medicine offers countless strategies to medicalize risk, that is, to treat the risk of future illness and death as a medical problem requiring medical solutions. The practice of taking medication has become ubiquitous and therefore accepted as a natural part of modern life. But bioethicists question whether this medicalization is ethical or unethical in itself, given that one danger to consider is the risk of drug side effects, often overlooked.

**Medicalization as an idol**

Nowadays, the concept of health is subject to excessive medicalization, and the impact of this phenomenon, as Michel Foucault warns us, is obvious: "*Today, if you want to maintain a healthy life, there is no other way than following the norms and directives of modern medicine, which correlate every stage of human life*" (Foucault, 2003).

Medicalization represents the answer to scientific progress in the medical field, and its scope is immense, given the fact that it extends over our entire lives: nutrition - diets, specialized drinks for athletes, etc.; cosmetics and body care industry, mental comfort, etc. Thus, from medicalization, we reach an area of the psychological which, it seems, is the key that makes us see medicalization as a versatile phenomenon. A relevant example, in this sense, is the tendency of contemporary society to beautify the human body through modern technologies of its own accord. I remember the interview of a great Italian surgeon, university professor, who said "*there is plastic surgery of necessity and plastic surgery of vanity*". In other words, one is an aesthetic operation applied to a burn or a person who has been through an accident, and another is the placement of silicones that some women resort to. We don't know if the mentioned surgeon is a Christian or not, but his common-sense observation leads us to think that we will, of course, be resurrected with a spiritualized body at the Last Judgment. However, it is hard to believe that the silicones added to different areas of the body will be part of the resurrection from the body of some women.

We are in a situation where people's behaviours are defined in medical terms. The idea is that phenomena, once considered natural, such as senility, shyness, attention deficit hyperkinetic disorder, anorexia, chronic fatigue syndrome, social phobia, etc. they can be treated with drugs or surgical procedures. Therefore, medicalization is related to the effect of chemical substances, to the way they are marketed, prescribed, but also to the relationship that is established between politics, the pharmaceutical industry and the doctor. There is a lot of money to be made from metamorphosing healthy people into sick people and turning health into a commodity (Moynihan & Henry, 2006).

Economists teach us that the primary good is to maximize life span. This is the idea behind the practices promoted by the medicalization of risk. They still continue to believe that longevity is one of many assets. I also think that all goods are best thought of in terms of

extension, and I exemplify the advantage of a larger income over a smaller one by relating it to a longer life being preferred to a shorter one.

If "*successful societies*" are equated with the healthiest and longest-lived populations, we can think of the phrase as being used in a manner considered idiosyncratic. Undoubtedly, keeping the members of a community alive is a major social and political success for any society, just as other dimensions of "*success*" (human rights, democracy, material prosperity, etc.) might seem equally or even more important. Delving into this topic, Peter A. Hall and Michèle Lamont (2009) rhetorically ask if Cuba's population having a life expectancy similar to that of the United States of America means that Cuba is an equally successful society? Was the Russian society of the 70s of the last century more successful than the Russian society of the turbulent 1990s, just because Russia experienced a dramatic drop in health indicators after the collapse of communism? But if we consider democratic participation to be a component of "*plus health*," then the US certainly appears to be significantly better off than Cuba, despite similar health outcomes in the narrow sense (Hall & Lamont, 2010).

Yet this intuition fails to capture the essential finitude of our lives. Although it is true that human beings have a desire for the transcendent, that is, a kind of infinite good that they identify with God, it must be understood that this cannot be approached through an endless succession of finite goods (Hirschfeld, 2023). In this thinking we might be tempted to believe that instead of seeking new medical treatments to ameliorate the human condition, we should cultivate the virtues that enable us to cope with our vulnerabilities.

Today reality shows us that 50% of diseases, infirmities and deaths are the result of the lifestyle that people adopt. Control over risk factors, such as unbalanced diet, excessive alcohol consumption, smoking, drugs, sexual promiscuity, environmental pollution, etc., or in theological terms "*falling into sin*", could prevent 40-70% of all premature deaths, 33 % of all infirmities and 66% of all chronic diseases.

Insofar as we regard science, technology, and public policy as the main engines of "*progress*" in the attempt to ameliorate the human condition, one must consider the passivity of the population as being in some tension with our stated concerns for the human person, and namely freedom.

Because modern medicine has set itself the goal of avoiding disease and death, we sometimes forget that the purpose of healthcare is to express love and concern. Take for example the end of life, where patients are often reduced to lab reports and charts. The heroic and at the same time painful efforts to treat incurable diseases at any cost at the request of the patient or family, who often create false beliefs about the power of medicine, do not take into account the well-being of the person concerned, demonstrating a concern more for the body and less for the person.

Bioethicists wonder if unnecessary treatments can be banned? We believe that it would be more useful to understand the notion of incurable, because there are no clear professional standards to base the medical decision on. In addition, the principle of patient autonomy is not an absolute one, because the doctor does not grant treatments to those who do not enter into the legitimate purposes of his profession, such as e.g. administration of steroids to athletes, and in the field of medical treatments, the patient cannot be excluded from the decision.

An exception to the refusal of unnecessary treatments can be made by the doctor out of compassion, when he continues the treatment to allow the dying person to see a relative again, for example. In this situation, the patient has a purpose in life. However, it must be understood that in the created situation the doctor does not have such an obligation, but only an option. The desire to extend a curative treatment that is known to be ineffective is the rejection of a death that we do not accept. In the case of the doctor, this can be considered as a failure of a professional mission.

The purpose of medicine is to fight disease and death. However, healing a disease at any cost, without taking into account the unity of the being in its body and soul, means ignorance of the nature of healing and unnecessary prolongation of suffering and anguish. The therapeutic severity resonates with the cry of despair of the one to whom death causes fear and which he rejects because it expresses no hope, as if God did not exist. In other words, the person in question does not agree with the belief in the Resurrection and eternal life.

In one of his sermons, St. John Chrysostom asks rhetorically: What is so terrible about death? Tell me. Is it that it makes it much easier for you to enter the harbor and stay of the blissful life? You hope for goods that eye has not seen, nor ear heard, nor the heart of man tried, and you delay to go and rejoice! If you believe, show your faith by your works. Or, how will your works bear witness to your faith? But you put the fear of death above. For one for whom the fear of death is not a passing, a slumber, the severity of delaying the step towards a life that has always been considered "*better*" cannot be conceived, for this would mean putting an end to the continuation of earthly life (Beaufils, 2023).

**Conclusions**

1. For many people, the technical development of medicine is a sign of progress, and the arguments that are given are the decrease in infant mortality and the increase in life expectancy.
2. The problem of the boundary between normal and pathological remains delicate, especially since the scientific independence of medicine is threatened by financial interests.
3. Preventive medicine offers countless strategies to medicalize risk, that is, to treat the risk of hypothetical future illness and death as a medical problem that requires medical solutions.
4. Bioethicists question whether this medicalization is ethical when it tends to be transformed from a real good into an idol.

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