The Review

Medicalisation, morality, and addiction :

why we should be wary of problem gamblers in primary care

In the 35 years since Ivan Illich led a vanguard of searing medical-scepticism with his *Limits to Medicine: Medical Nemesis, the Expropriation of Health*,[1] critiques of medicalisation may have become less fashionable, but no less necessary. The continuing need for a critical perspective on medicalisation is apparent at a time when the UK media displays a violent backlash against people with drink and drug problems; when the British Prime Minister defines the optimal method to 'get drug addicts clean';[2] and when the Chair of the RCGP endorses an addiction model for addressing 'problem gambling' in primary care.[3]

MEANINGS OF MEDICALISATION

Medicalisation is the 'process by which non-medical problems become defined and treated as medical problems'.[4] A recent *BMJ* article on the subject perceived 'medicine's imperial project': the medical profession determinedly defining new diseases and broadening the diagnostic criteria of old ones (so much so that 'virtually the entire older adult population is now classified as having at least one chronic disease').[5] However, medicalisation is frequently a more complex phenomenon than the united professional advance implied by analogies with imperialism. The processes of medicalisation may be as varied as the problems medicalised (pregnancy,[6] masturbation,[7] and repetitive strain injury[8] for example, have fascinatingly unique, and mercifully unrelated, medical histories). Furthermore, sociologist Ellie Lee has described uses of medicalisation that even the most anti-imperialist, anti-establishment agitators among us might find it difficult to disapprove of: 'battered woman syndrome' has been valuably employed in the legal defence of women who have killed their abuser; post-traumatic stress disorder (PTSD) gained benefits for unacknowledged US Vietnam war veterans in the 1980s; and a PTSD diagnosis still occasionally halts the Home Office from returning an asylum seeker to a country where they have been tortured.[9]

Arguably though, the immediate gains from medical recognition of the consequences of issues such as these occur at the cost of more challenging, but ultimately more meaningful, societal recognition of their causes. Being battered by one's partner; going to war; being tortured; these are all experiences that might prompt moral discourse more appropriately than medical diagnoses; and it might reasonably be considered that they are bad things in and of themselves, quite aside from any consequent medical conditions.

MEDICALISING MORALITY

Morality and medicine are often entwined. Susan Sontag described the metaphors by which disease may be (im)moralised;[10] medicalisation commonly describes the means by which immorality becomes 'disease'. So, when homosexuality was 'immoral', it became made 'medical'; and 'moral' anti-abortionists tried (and failed) to show that abortion caused psychiatric problems. Once an issue is made medical it is removed from the moral sphere and any further debate about its right or wrongness, or its causes and consequences, is silenced. Quite simply, once the 'disease' label has been applied, its subject becomes inherently bad and must necessarily be treated (preferably cured) without confronting any of its moral ambiguities.

For example, so long as drug and alcohol problems (each of which moved from the moral to medical domain in the 20th century) are viewed with a purely clinical gaze their more troubling social and moral aspects can be conveniently overlooked. Yet, just as these problems persist, so moral prejudices endure. While people with drug and alcohol problems have been medicalised, societal attitudes toward them have simmered, boiling over recently in the heat of media furore over what the *Daily Mail* headline described as 'the disability benefit that's handed out to addicts and alcoholics' (the BBC reported the issue with similar emphasis). The moral disavowal of people with drug and drink problems was clear; their claims to disease status and attendant benefits were deemed less valid than those of people with other ailments: 'a disability benefit for those who cannot walk or get around properly is being given to tens of thousands of claimants with drug and alcohol problems'.[11] For patients whose issues are medicalised without the moral difficulties being confronted the dangers of short-term (financial) gains at the cost of longer-term losses (continued moral stigma) are here evident.

ADDICTION AND ITS MEDICAL MODEL

Moral prejudice is bound into medical attitudes towards drug problems. 'Addiction' has become synonymous with 'substance misuse' which is itself often synonymous with the only marginally more moralistic 'substance abuse'. Meanwhile, 'addict' is short-hand for a drug-dependent person and all too easily becomes clinical code for someone who is manipulative and untrustworthy. The prevailing UK model of addiction, defined daily in thousands of methadone scripts, is one of chronic physiological drug dependency: this model sustains the stigma for 'addicts' at the same time as it sustains itself (medical control being reinforced by physician-sanctioned substance-replacement therapy and pharmacological management of withdrawal states using prescription-only medications).

However, current medical concepts of addicts and addiction management have come under attack from the Prime Minister. Harm-reduction is not for him; David Cameron aims for abstinence: the even-more-moral hard-line of eradicating illegal drug use entirely. 'In the end, the way you get drug addicts clean is by getting them off drugs altogether', he has confidently asserted.[2] While avoiding confrontation with the social determinants of illegal drug use, Cameron advocates residential rehabilitation and greater criminalisation of drug use: shifting the issue from the clinic to the criminal justice system. It remains to be seen whether Cameron's proposals will be implemented, and whether they will work in any useful sense. Whatever the most appropriate policy, it is clear that drug addiction and its medical model remain highly subject to the moral–political environment, emphasising the medically-enhanced vulnerability of medicalised addicts.

MEDICALISING 'PROBLEM GAMBLERS'

'The UK is in the midst of a profound economic decline and the failing economy could be linked to increases in problem gambling as individuals bank on big wins to deal with reducing finances.'[3]

George Sanju and Clare Gerada, Chair of the RCGP, cite no sources to support this, the opening statement of their recent editorial which claims that 'GPs have a

crucial role in addressing problem gambling in primary care'. No available evidence upholds their conjecture of apparently desperate 'individuals' with dwindling finances causing an upsurge in 'problem gambling'. A far more plausible explanation for any increases in gambling, problematic or otherwise, is provided by the Gambling Act which came into force in 2007 and enabled casinos, bookmakers, and online betting sites to advertise on TV and radio for the first time in the UK and which eased restrictions on the opening of betting shops and online gambling sites, resulting in their recent proliferation ('BetterBet' had 25 high street outlets in 2007, but planned to increase that to 200 shops following implementation of the new law).[12] In 2004 the author of a Royal College of Psychiatrists briefing warned the House of Commons against the proposed legislation,[13] but subsequently perceived that the government had ceded to the financial interests of the gambling industry: 'gambling promoters are to join investment bankers in not being allowed to go to the wall as a result of the recession. Punters and their families will pay a heavy price for this.'[14]

Sanju and Gerada frame 'problem gambling' using the same biomedical model of disease applied to other addictions:[15] focusing on 'individuals' and abstracting the issue from its rightful socio-political context (which might include reference to a restrictive class structure and social inequities, as well as dubiously-motivated legislative changes). Onset of the disease then becomes explicable only by misfortune, or some sort of innate fault or failing within the individual (here the failing is in their reaction to 'reducing finances'). Our response is inevitably patronising: pitying or, in this instance, pejorative. The punters will indeed pay a heavy price if we permit the application of morally-loaded medical labels to gamblers who themselves then become the 'problem'.

GAMBLING AS MEDICALISED IMMORALITY

Moral failing is implicit in the poignant timing and contemporary allusion of Sanju and Gerada's article. It has become virtually impossible to reference the 'failing economy' without evoking imaginings of irresponsible bankers squandering money in high-risk, high-stakes games of stock marketeering. By the same unconscious logic, Sanju and Gerada suggest that problem gamblers 'bank on big wins'. There is a disturbing sense in which the discussion of problem gamblers is being set to resonate with that of the much demonised bankers. The fact that they are being linked in an unevidenced chain of causality might alert us to this. And we should be alert to the risks of moralistic medicalisation of gambling problems at a time of social approbation towards anyone (royalty included) perceived to be squandering money during our current collective state of financial dis-ease.

> *"Medicalisation of an issue focuses attention and treatments on the individual; removing the problem from its political, legal, employment and social context ..."*

Yet the appeal of medicalising gambling problems is apparent. Waning religious and legal prohibition permit us to inherit this well-established crusade (inherently self-defined as moral and right); taking on the mantle of moral righteousness and enjoying the feeling that psychologist Steven Pinker has described 'when the moralisation switch flips inside us — the righteous glow, the burning dudgeon, the drive to recruit others to the cause.'[16] But these are not good reasons for 'problem gambling' to become a disease subject to primary care treatment; and the discussion above should suggest that there are good reasons for it not to.

CONCLUSION AND CAUTION

Medicalisation of an issue focuses attention and treatments on the individual; removing the problem from its political, legal, employment, and social context, and thereby relieving politicians, law-makers, employers, and other members of society of any accountability. It furthermore may turn a moral issue that might have been debated into a disease that must be eradicated. By these means may occur an erosion of social responsibility and of democratic principles.

GPs have a particular susceptibility to medicalising and consequently an especial responsibility to be conscious of it. Mike Fitzpatrick has warned that general practice is 'in many ways the front line of the advance of medical intervention in lifestyle.'[17] Our patients present problems that are frequently neither physical nor psychological, but social or even spiritual. For their sake and ours it is imperative that we possess a secure sense of what problems we might address usefully and which ones we risk medicalising with admirably-intentioned, but ultimately unhelpful, interventions (ranging from attempts to cure individual patients' social problems, to the government-mandated lifestyle interference described by Fitzpatrick).

There may be personal, political, public, and professional pressure for us to remove challenging moral problems by turning them into disease states. However, well-meaning, but ill-considered, medicalisation risks making vulnerable groups even more vulnerable when, for instance, not-very-robust disease models are subsequently attacked by forces beyond our professional control, such as politicians and the media. 'Addictions' and 'problem gambling', with their strong moral undertones, associated potential for political point-scoring and ill-understood psychological mechanisms are especially susceptible to medicalisation, with attendant dangers for those medicalised.

Valid medicalisation betokens valid medical management. Well-established precedents dictate that if we are to claim an ailment as medical we should be able to treat it, or ease the experience of it, or at least be prepared to invoke that other seemingly irrevocable symbol of the GP's social agency: the sick note (The Statement of Fitness for Work, or 'fit note', replaced sick notes (Med 3s) in April 2010). The sick note, in fact, may offer us a barometer of sorts: discomfort felt in sick-noting may suggest a problem inappropriately medicalised either by the individual or by the wider society. It is likely that few of us would feel comfortable sick-noting for 'problem gambling'. And it is painfully apparent that we would struggle to diagnose and treat it with any validity too.

Sanju and Gerada call for further debate on gambling problems. However, as events this year in the UK have shown, referenda on individual issues will be subject to the prevailing political winds and personality whims of the day. And in the processes of lobbying and lobbing the issue between proponents and opponents of a medical model, we risk making the problem 'medical' by medical handling. Instead, we need to develop a consciousness of

medicalisation as a potentially pervasive phenomenon, rather than as an occasional and unusual occurrence in the context of fringe diagnoses. We may need to make bold decisions about the sort of medicine we wish to practice and (Illich's *Nemesis* not withstanding) about the sort of profession we wish to be part of.

In 1969 *The Lancet* published a lengthy account of a conference on 'Compulsive Gambling ... sponsored by the Churches' Council on Gambling' (this was before Illich accused doctors of becoming the new priests).[18] It concluded: 'In the present state of knowledge, research should take precedence over extension of treatment facilities.' That remains true, but our research and further understanding of this and other issues should not only be biomedical, but also social, moral and political. And might include some personal and professional soul-searching too.

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